VOLUME TWO:

FIVE PROFESSIONAL PRACTICE REPORTS

by

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OVERVIEW OF VOLUME TWO

This overview outlines the local context in which the professional practice reports were completed within the role of the Trainee Educational Psychologist (TEP) as a requirement of the Applied Educational and Child Psychology Doctoral course at the University of Birmingham.

Volume Two describes the five professional practice reports (PPRs), looking at different aspects of the role of Educational Psychologist, completed during years 2 and 3 of the Supervised Professional Practice Placement.

Presented in the second year of the Professional Practice Placement, PPRs 1, 2 and 3 address the following areas:

- An evaluation of a specialist provision for children and young people who have been identified as having medical needs and for a variety of reasons are not included into mainstream schools (Harris and Farrell, 2004).
- Investigating the evidence base of social stories as an intervention to support an individual child with complex needs associated with his diagnosis of Autism.
- Multi-agency practices within locality teams to support the needs of individual children, families and schools.

The 4th and 5th PPRs were completed during the final year of the Supervised Professional Practice Placement and comprised:

- The role of the Educational Psychologist within the community context as a example of educational psychology using their skills in specialist work.

- An evaluation of the effectiveness of a group CBT intervention for children diagnosed with Asperger's Syndrome.

The Professional Context

For years two and three of the Applied Educational and Child Psychology Doctorate course at the University of Birmingham, I was employed by Kent County Educational Psychology Service. This is a large authority where teams of Psychologists are allocated to different localities within the county.

Traditionally, the role of the Educational Psychologist was seen as working with individual children conducting assessments and utilising psychometric testing. However, recent legislation, such as the government agenda set out in "Every Child Matters" (DfES, 2003), saw a repositioning of Educational Psychology Services within joint Education and Social Care departments within local authorities under the umbrella of Children's Services, with an emphasis on multi-agency working. The Kent EPS was affected by this development during my placement and Psychologists' roles were being re-defined within the local authority with more emphasis on working preventatively carrying out a range of whole school, class and small group interventions, as well as training and consultations with school staff and parents.

However, the transition was not yet complete and, within the service, Psychologists still had a statutory role linked to the Special Educational Needs Code of Practice (DfES, 2001). It is also important to note that each locality team had developed their own individual multi-agency practices, with varying degrees of synergistic success, often dependent upon local logistical circumstances. For example, in some localities staff from one or more different agencies were based within the same building while in other locations Psychologists would rarely get the opportunity to meet their multi-agency counterparts.

During the second year of the Professional Practice Placement, I worked within the Dartford locality team, where the Psychologist's role and work was commissioned through a monthly multi-agency referral meeting. Schools were not allocated any Educational Psychologist's time other than through the requirements associated with the statutory assessment requests. The remainder of the Psychologist's time was negotiated through the monthly multi-agency referral meeting. For example, if a school within this locality required Educational Psychology support, whether for an individual case, a group or for In-Service Training, a request had to be submitted to the multi-agency team who were responsible for allocating relevant resources.

During year three I was based within the Gravesham locality team. Although there was some multi-agency practice within this locality - such as the development of the Single Point of Access and Common Assessment Framework - Educational Psychologists allocated much of their time to schools directly. This was done through a termly planning meeting where Educational Psychologists consulted with schools regarding the needs of individual children, groups and any staff development. Consultation is used widely within the service as an

approach, particularly in the initial planning meetings, and aims to bring change to individuals, groups and at a systemic level based on the Consultation Model presented by Wagner (2000). Although the Special Educational Needs Coordinators (SENCOs) –often prioritise individual children they are encouraged to consider more systemic work such as staff training and evidence-based interventions.

OVERVIEW OF PROFESSIONAL PRACTICE REPORTS

Professional Practice Report 1

Within the Dartford locality there are a number of provisions which aim to meet the needs of children who, for a number of reasons, are not included in mainstream schooling. The PPR1 paper explores one such provision. The DfES document "Access to Education" (2001a) suggests that up to 10% of children between the ages of 5 and 15 experience clinically defined mental health needs and many of these children are also educated outside of the mainstream school system.

The first PPR focuses on the specialist provision within West Kent known as "West Kent Health Needs Education Service" (WKHNES). The purpose of this provision is to meet the needs of school aged children not attending school due to medical illness, injury and mental health needs.

In discussions with professionals working in WKHNES, it became apparent that there were two conflicting viewpoints concerning the long-term benefits and effectives of these provisions for those pupils who could potentially be re-integrated back into the mainstream school system. My role included research and discussions with pupils, staff and parents to understand in more detail some of the barriers to the re-integration of children into the mainstream school system.

Professional Practice Report 2

A proportion of my work involved working with individual children with complex needs. PPR2 outlines a case study of a primary aged male who was diagnosed with an Autism Spectrum Disorder (ASD) and a review of the evidence base of interventions to support his complex needs.

From my research it became evident that there are a number of interventions currently available to schools and parents to support the social communication and interaction difficulties that are presented often in children with Autism. As an Applied Psychologist it is important to understand the evidence base for such interventions to ensure schools and parents are able to make informed decisions about best practice. The report concludes that, although there seems to be an increase in popularity for the use of social stories in schools, there are questions which arise regarding the limited empirical evidence and knowledge of the long-term effectiveness of such interventions.

Professional Practice Report 3

As part of my practice in Year 2, I worked within a multi-agency team and a percentage of my work was commissioned through a process known locally as a "Partnership Based Review" (PBR), a monthly meeting of multi-agency professionals where individual cases or systemic processes are discussed, with a view to allocate appropriate professionals' time and other available resources.

As the PBR was in its early stages, it was deemed important by the professionals involved to evaluate the process in regards to its success in meeting the needs of its service users i.e. local schools and families. The report concludes that although the move to multi-agency working has numerous potential benefits, the concept of "multi-agency working" is difficult to operationally define and evaluations of its effectiveness are therefore problematic in practice.

Professional Practice Report 4

The role of the Educational Psychologist is gradually expanding and there is scope for EPs to become involved with research projects and interventions that have a community focus rather than the more traditional focus of schools. This was evident particularly through this professional practice report. PPR4 discusses the role of Educational Psychologists within the community, with a particular focus on minority groups.

PPR4 is a summary of the Educational Psychology Service's work with the Slovakian community within the Gravesham area. The recent increase in New Arrivals to the local area prompted the Educational Psychology service to reflect on the access to educational services for this particular community. The fourth professional practice report draws on theories of Community Psychology, with a particular interest in how the concept of empowerment can promote effective collaboration between service providers and disempowered communities.

Farrell et al (2006) suggests that a distinctive contribution can be made by Educational Psychologists to support the gap between the school and the community. In terms of the project, this was certainly a key aim of the Educational Psychology Service. In order to

provide services to the community the Educational Psychology service felt their views and experiences of educational services was an important step in building bridges between the community and the school.

Professional Practice Report 5

According to Cameron (2006), Educational Psychologists can have an important role in promoting mental health and well-being for children and young people within the school context. Many services are exploring the possibility of using psychological therapies such as Cognitive Behavioural Therapy (CBT) to promote this. However, often limitations associated with time and role constraints mean that the long-term investment, that can often be a requirement of approaches such as CBT, create a challenge for Educational Psychologists.

The fifth professional practice report explores the theoretical underpinnings of CBT and the use of such therapies with children and young people who have a diagnosis of Asperger's Syndrome. As part of the Gravesham Locality Team's service plan, the Educational Psychology service began to discuss possible collaborations with the Child and Adolescent Mental Health Service. This led to a joint project using CBT intervention to support a group of children aged between 11-12 years of age who were diagnosed with Asperger's Syndrome and had related mental health concerns such as anxiety and anger.

The PPR highlights the research which discusses the use of CBT with children and young people, and in particular how it can be adapted for children who are diagnosed with an Autism

Spectrum Disorder. The issues of using CBT with children and young people are discussed along with how parental involvement impacts on the success of such groups.

Professional development

My placement as a TEP has provided me with varied opportunities to work at many different levels of context, from individual children, groups, at the organisational level and with the within the wider community context.

Self reflection, peer and professional supervision have supported my own personal and professional development allowing me opportunities on a regular basis to identifying my own areas of strength and development. Working within two localities enabled me to build positive relationships with colleagues, multi-disciplinary professionals and school staff.

Through the five professional practice reports I have been able to reflect critically on many aspects of the role of Educational Psychologist and utilise my position as a TEP to understand the research and theoretical underpinnings of the many aspects of our work.

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PROFESSIONAL PRACTICE REPORT ONE

An evaluation of the re-integration of pupils with medical needs into mainstream schools.

"In any given year there are some 100,000 children and young people who require education outside school because of illness or injury. In addition, there are a significant number of children and young people who experience clinically defined mental health problems which result in frequent absence from school."

(Taken from DfES 2001a pg 4)

Abstract

The Department for Education and Skills (DfES) document Access to Education (2001a) has highlighted the large proportion of school-age children not attending school due to medical illness, injury, and mental health needs. In addition, a report on promoting children's mental health within the early years and school settings (DfES, 2001b) suggests that up to 10% of children between the ages of five and 15 experience clinically defined 'mental health needs', and many of these children are also educated outside of the mainstream school system. Therefore, there are a significant number of children with medical needs who, for a variety of reasons, are not included in mainstream schools (Harris and Farrell 2004).

This paper will review the government legislation and policies that currently identify the needs of children with medical conditions, and also highlight the education of these groups as an important aspect to consider, particularly for Local Authorities (LAs). This paper will begin by defining what is meant by children who are out of school due to medical illness, injury, and related mental health needs. The re-integration of this group of children back into mainstream school after a long period of absence will also be discussed.

The literature surrounding these issues will be reviewed and alternative provisions, such as Hospital Schools (which have been established by some Local Authorities); to meet the needs of these groups will also be considered for their effectiveness. A particular focus of the paper

will be to conduct exploratory small scale research into the effectiveness of one specific provision; the West Kent Health Needs Education Service (WKHNES). The purpose of the provision and how it tries to meet the needs of children with medical/mental health needs will be identified along with the strengths and weaknesses of the provision's practices relating to reintegration.

The views of teachers and pupils within this provision will be sought and discussed with the aim of identifying how provisions such as WKHNES attempt to meet an inclusive agenda through their re-integration process and the challenges this may create.

Before I to discuss in detail the government policy and research relating to this topic I will begin to define children who are identified within the definition of children with medical needs. The following definition is used in this paper as I feel this highlights not just children with physical injury but also children out of school due to complex and ongoing mental health needs.

Lightfoot et al (1998) define children with medical needs as those with:

"medical conditions which, if not properly managed, could limit their access to education. Children with a chronic illness or physical disability who are known to be at increased risk for psychosocial adjustment problems when compared with their peers." (Lightfoot et al 1998 and Wallander & Varni 1998).

Summary of government policy in relation to children with medical needs

In recent years the agenda of inclusion has become a key aspect of the development of education policy and practice around the world. These developments have, in part, been informed by ongoing debates in the field of special education that have focussed on questions about which forms of provision should be made available for children with disabilities and others who experience difficulties due to injury or mental health needs. In the United Kingdom the Government's discussion paper *Excellence for all Children: Meeting Special Educational Needs* (DfEE, 1997) and the subsequent *Programme of Action* (DfEE 1998) referred to the right of all pupils to be educated in a mainstream school wherever possible. More recently, the revised *Code of Practice on Special Educational Needs* (DfES 2001) and the *Special Needs and Disability Act* (DfES 2001) provide yet further impetus towards the concept of a more inclusive education system.

This provides an ongoing challenge for schools and LAs who are attempting to develop more inclusive approaches to working with all children. In order to address these and related problems, the government devised a public consultation exercise involving all major stakeholders which took place between November 2000 and February 2001.The focus of the consultation exercise was the group of children unable to access education for reasons relating to long-term illness and related mental health difficulties. As a result of this consultation the Department for Education and Skills (DfES), together with the Department of Health, published statutory guidance entitled *Access to Education for Children and Young People with Medical Needs* (DfES, 2001a).

The *Access to Education* (2001a) guidance contributes to the Government's strategy to promote equal access to education for all children and young people. This strategy is being developed through the amendments made to the *Disability Discrimination Act 1995* and the *Education Act 1996* by the *Special Educational Needs (SEN) and Disability Act 2001*.

This guidance (DfES 2001a) applies equally to all those pupils who are unable to attend school because of medical needs, those who are physically ill or injured and children with mental health problems. The guidance suggests that particular care is needed to ensure that

there is adequate provision for pupils suffering from mental health problems. It goes further to suggest that children with mental health needs such as anxiety, depression, separation anxiety and school refusal associated with depression, which prevent them from attending school, may need support from specialist mental health services (DfES 2001: *Access to Education* pg 5).

Following the publication of the guidance (DfES 2001a) a review of services and good practices was conducted by Farrell and Harris (2003 and 2004). This research provides valuable information relating to existing practices and provision for children with medical needs and the widespread agreement on key principles that should inform the development of improved services for these children. However, the research also highlights evidence of underlying areas of concern that need to be addressed. These were defined as:

- Barriers to accessing education
- Multi-agency effectiveness
- Provision and dissemination of information
- Need for statutory guidelines to promote best practice
- Re-integration into mainstream education
- Accountability
- Local variation in quality of provision

(Farrell and Harris 2003)

Following an in-depth consultation, the Access Document (DfES, 2001a) suggested a change in attitude and policy from the previous 12/94 document (DfE, 1994). This statutory guidance, released in partnership with the Department of Health, aims to deal with these concerns by providing a set of minimum national standards and encapsulates the responsibilities of all those who have important roles to play in providing education for children and young people with medical needs including mainstream schools, related professionals and Local Authorities. Additional focus is given to the issue of when education should be made available to children and young people with recurrent or long-term medical needs, with

expectations placed on services/hospital schools to provide education immediately for children/young people who have planned/regular admission dates.

The review conducted by Farrell and Harris (2003) not only highlighted areas of good practice but also reviewed the history of research into this particular group. Some key pieces of research into this area were conducted by Boulton (1997), Closs and Norris (2000) and Lightfoot et al (2001). These studies have been highlighted because until recently children and young people with medical needs have been given little policy and research attention than children with other types of need. Research on service support and communication between health and education services for children with medical needs commissioned by the National Health Service (Lightfoot et al, 2000 and Lightfoot et al, 2001) has documented the weakness of previous policy and guidance in this field, citing how guidance was limited in scope and not specific in defining responsibilities.

Boulton's (1997) qualitative study with a small sample (8 families) is highlighted in this paper as it could be viewed as a significant published piece of research in the UK which evidenced interviews from parents and children who had experienced long term sickness and were out of school because of this. The research was commissioned by the National Association for the Education of Sick Children and Boulton (1997) highlighted that the previous DfE guidance was insufficiently flexible, especially in the area of the time delay allowed (four consecutive weeks), before home tuition services are activated. She stated that the guidance discriminated against children who may experience frequent but short absences from education due to illness.

Closs and Norris (2000) have also been cited in the Farrell and Harris (2003) review as their research highlighted key factors involving the education of children with illnesses that require absences from school. They conducted two projects over time which involved both questionnaires and semi-structured interviews with children and professionals involved with the care of this group. Their projects were conducted over a number of academic years therefore providing in-depth information about the long terms needs of this group. They highlighted that experiencing illness or injury has the effect of disrupting normal life experiences – with disruption in education being a prime example. Children and young people

with medical needs may experience, at some time and to varying degrees, a 'constellation of factors' (Closs, 2000) which may place their education at risk. Disruption to education can happen in a variety of ways including:

- The single, medium/long term period of time out of school that may derive from a relatively uncomplicated accident or one-off illness;
- The repeated interruptions associated with serious chronic illness, which can lead to a fluctuating pattern of school attendance;
- The effect of degenerative/terminal illnesses where a child may develop associated cognitive problems leading to a reduction in academic/physical ability over time;
- Short but frequent absences from school associated with illnesses such as asthma;
- Regular short absences for treatments;
- Long/permanent absences out of regular mainstream placements which can be associated with psychiatric illness and also Chronic Fatigue Syndrome.

(Boulton, 1997 cited in Closs 2000)

According to the research conducted by authors such as Boulton (1997) and Closs and Norris (2000), although access to suitable alternative education during times stated above has many benefits educationally, socially and emotionally few studies concentrate on the interplay between education, health and emotional well-being. The authors suggest three reasons for the scarcity of research into this particular area:

- The ignorance about health-related issues among teachers and other related educational professionals;
- Research reluctance; at a time when medical/deficit models of Special Educational Needs (SEN) have been discredited and superseded by social models of disability, researchers have been reluctant to become involved with issues that bring 'within-child' factors and medical related issues to the forefront.
- In a time when inclusion has achieved prominence as the way forward for effective education, it seems that this complicated issue has been left on the fringes. Substantive literature exists on the negative impact that exclusion from education has on life

opportunities. However this does not seem to have included exclusion as a result of illness/injury.

These conclusions are susceptible to criticism on several fronts. For example, the sample size achieved in both studies is limited. Furthermore, Boulton's (1997) research was conducted more than a decade ago, since which time significant changes have taken place within the educational environment. In addition, Boulton (1997) focused on the views of children with medical needs and their parents. Therefore commenting on professionals' practices without seeking views from professionals who work with this group can be seen as unbalanced.

More recent research, for example Lightfoot et al (2001), conducted from the perspectives of professionals who worked with this group of children would also disagree with the comments from Boulton (1997) and Closs and Norris (2000) regarding professional ignorance relating to health-related issues. Lightfoot et al (2001) suggest a lack of professional knowledge and training in certain medical conditions may be a factor in their overall level of awareness for this group.

On the basis of her research, Boulton (1997) suggests that what is required is an exploration of the education systems and procedures which are most effective in safeguarding and promoting children's social and emotional well-being. She suggested that children need a) to be as normal as possible, b) to be listened to, and c) to be treated as individuals so that they can feel better before they start to think about education. Extra help at times, provided as far as possible within the context of their everyday school life, and the help they receive out of school should be closely linked with their particular educational path, their interests, and their goals; and for their schools to stay closely in touch with them and be involved with their education out of school and for pupils to remain in contact with their friends.

This highlights the key issue of emotional wellbeing and continuity for children who are out of school for medical or mental health related concerns .Boulton's (1997) research links well with current primary and secondary school government initiatives entitled *Social Emotional Aspects of Learning* (SEAL) (DCSF 2003). However, it should be noted that Boulton's (1997) study focused on interviews with parents and children and is therefore open to interpretation

by the researcher and other professionals. Therefore, the conclusions are also open to differing interpretations.

A more recent piece of research conducted by Poursanidou et al, (2008) where they interviewed 11 teachers who had worked with children with chronic illness found that the importance of hospital–school liaison that is proactive, preventative and strategic in nature have a particular relevance for policy and practice in the context of the current *Every Child Matters (2004)* agenda, and are likely to have wider applicability to the education of chronically-ill children at large.

They state that the need to improve inter-agency cooperation and integrated working across child safeguarding services reflects a current key policy priority in the UK in the context of the *Every Child Matters* agenda (Department for Education and Skills, (2004).

Research into children with medical needs

When conducting the literature review, it quickly became apparent that issues related to the access to education for children with medical needs are numerous and complex. This is primarily due to the diverse nature of the population, which includes a wide range of children whose experiences will differ dramatically. Children and young people who may experience short-term injuries such as broken limbs will have very different needs both educationally and medically to those who are chronically sick or suffering from mental health problems.

Lightfoot et al (1998) conducted semi-structured interviews with 33 mainstream secondary school pupils. One of the main findings of the research was a need for improvements in communication between health staff and teachers. According to Lightfoot et al (1998), successful inclusion depends upon children receiving appropriate support for their special health needs. Many different types of education and health staff potentially have a part to play in supporting this group of pupils, including: teachers; Local Authorities (LAs); learning support staff; school care assistants, administrative and catering staff; school nurses and school doctors; specialist nurses; therapists; and medical consultants. Collaboration is needed between these staff to ensure appropriate support is in place for individual pupils. The research conducted by Lightfoot et al (1998) is supported by the findings of the report conducted by Farrell and Harris (2003), which highlighted the need for effective communication amongst multi-disciplinary staff.

Views of professionals

A number of studies have been conducted from the perspective of professionals who work with children who have ongoing medical and mental health needs. These studies have focused on teachers' knowledge about specific chronic illnesses – diabetes, cancer, leukaemia, epilepsy, and asthma – and have suggested in their findings that teachers are often ill informed about the conditions and receive little professional advice and support to help them manage the education of these pupils (Eiser, 1980; Bradbury and Smith, 1983; Charlton *et al.,* 1986; Eiser and Town, 1987; Lynch *et al.,* 1992; Court, 1994). However, more recent changes in legislation such as the introduction of the Disability Discrimination act (DDA 2004) has

put more ownership on schools to ensure they train staff appropriately and put in place procedures which allow for the inclusion of all children including children who have long term medical needs.

Even with the introduction of the DDA (2004), researchers such as Seymour (2004) argue that there is still much work to be done in engaging mainstream schools as full and proactive partners in the provision of education to those pupils unable to attend school.

Christine Seymour (2004), who at the time of the study was a Headteacher at a hospital school, conducted 2 case studies interviews with secondary age pupils. She discovered that one of the problems for mainstream schools is incidence frequency, and states that schools have a considerable agenda for raising standards of attainment and achievement for the children who attend regularly. In the secondary phase of education particularly, there is perhaps more likelihood of schools having to deal with disaffected young people and unauthorised absentees than with children absent on health grounds. So when a case occurs of a child's enforced absence for medical reasons, it is understandable that the mainstream school looks to specialist services to offer support and advice. However, whilst Seymour's (2004) conclusions may be accurate for the small sample used in her study, it may not be appropriate for generalisation to all children with medical needs, as noted by authors such as Boulton (1997). Due to the diversity of needs for this group of children some may manage better in their educational attainment than others. It is the small group of children who have ongoing needs and are out of school for longer than the recommended government guidance for which schools may seek support through home tuition services and other educational professionals.

Much of the research, including Seymour (2004), does not address issues such as funding, status of hospital schools and services, appropriate training for teachers, accommodation in hospitals and the growing numbers of young people with complex psychosocial needs as barriers to education/ inclusion of this group which still requires in-depth research. What these studies do highlight is the perspective of the mainstream school and some of the barriers which prevent this group of children from having full access to mainstream education. Again,

the research does not provide full accounts from the perspective of health professionals, parents, and children with medical needs.

More recent research conducted by Poursanidou et al, (2008) where 11 teachers were interviewed of which seven were in secondary and four in primary education. They also interviewed four health professionals. The themes raised from the interviews included:

- Teachers' attitudes towards collaboration with health staff – they found that most teachers had a positive attitude towards working with health professionals.
- Type of school attended by children with transplants –On the whole, teachers in primary and special schools were portrayed as more interested and willing to liaise with health staff, compared to their counterparts in secondary and mainstream schools. Mainstream secondary school teachers, in particular, were depicted as 'harder to engage'
- Knowledge and clarity with respect to other professionals' roles and responsibilities – Health professionals indicated that lack of knowledge and clarity on both health staff and teachers' part as regards each others roles and responsibilities in relation to children with medical illnesses.
- Availability of time and resources or staffing for liaison purposes.
- All professionals highlighted the need for a proactive and preventative model of hospital–school liaison

The issue raised in this study highlight the potential barriers faced by teaching staff and the lack of communication perceived between schools and health professionals. The research however was published in a health journal so may have been published with a view point that maybe more accessible to health professionals rather than educational staff. No detail was provided about the views of children who are affected by long term medical needs and this appears to be an area of limited research.

Views of Parents

Boulton (1997) researched 100 parents whose children had spent time out of school as a result of a chronic illness or accident, and 40 such children were interviewed about education provision. The report highlights the importance of continuity in education for this group of pupils and that this can be difficult when a child moves between the hospital, home and school at different stages during their illness. Parents wanted a single person to co-ordinate their child's education during this process. The author recommended the development of a model for liaison between hospital, home education services, and mainstream school.

More recently Asprey and Nash (2006) conducted semi-structured interviews with 41 parents who volunteered to take part in their research project. The 41 parents covered 10 LA's and all parents had children with life-threatening medical conditions. Asprey and Nash (2006) found that 43% felt that schools and colleges knew a lot, whereas 32% felt schools only had a basic level of knowledge about their child's difficulties. They identified areas of development such as awareness and communication with parents, awareness of absence from school, and awareness of multi-agency communication. These findings coincide with many of the findings highlighted by Harris and Farrell (2003, 2004) and suggest that this is still a concern for parents and professionals working with children with medical conditions. However, the majority of the research focuses heavily on children's medical needs and does not discuss in detail any related mental health concerns for these children.

It is essential to acknowledge here that this article draws upon interview data generated by two relatively small and opportunistic samples of teachers and health professionals. The process of data analysis also lends itself to some criticism as the researchers interpretation of the data may have impacted on the overall analysis.

Views of children

The views of ill and disabled pupils themselves constitute a particular gap in existing knowledge. Despite a growing awareness of the importance of engaging directly with children in research rather than using adults as representatives, disabled children remain a neglected group (Beresford 1997). Yet, without their perspective, services are unlikely to be tailored to

their needs, since the views of adults do not necessarily represent those of children (Tackett et al, 1990) and Woodhead, 1990).
Studies which have sought the views of children suggest that they have a number of problems managing school life. One UK study involving 40 children and young people, with a variety of health conditions causing periods of absence from school, drew attention to pupils' concerns about the impact of absence on keeping up with school work and maintaining relationships with their peers (Boulton 1997).

In research carried out in the United States with 200 families of children with asthma, parents and children identified a number of difficulties in managing asthma in school, including: the side effects of drugs, such as tiredness; teachers limiting access to medication; and routine exclusion by teachers from physical activities which could be beneficial for the child (Freudenberg et al. 1980). In both of these studies, the authors recommend more direct communications between health professionals and school staff.

The research conducted by Boulton (1997) has been positively received by professionals and has been highlighted within the review conducted by Farrell and Harris (2003). The project was commissioned by a children's charity and the research has been identified as providing valuable insight into the views of children who have medical needs. However, Boulton's (1997) study has limitations, particularly when exploring mental health concerns of children and young people. This could be an area of further exploration by researchers in this field.

More recent research conducted by Asprey and Nash (2006), where they interviewed 47 young people with a range of chronic illnesses attending mainstream primary and secondary schools, found that the majority of the young people interviewed felt that their views and concerns were not addressed, leaving them feeling unheard. Also 20% of the sample felt that, because there needs were not visible and the schools level of awareness was low, they were not viewed as having special educational needs.

However, like many of the research papers discussed, this paper was a qualitative study and interviews were interpreted by the researchers who, in this study, were working for a children's hospice. This may have contributed to researcher bias. Also, the results of this

study would be difficult to generalise as medical needs vary and for each child and the level of educational need will also differ.

Research into integration/transition

Although there exists research highlighting professional policy, good practice, and service review with regards to meeting the needs of children with medical conditions, there appears to be limited research available on the process of re-integration of children after a period of absence from school and the implications for this on their education.

A study by Nabors et al (2008), which surveyed 247 teachers from 15 Midwestern elementary schools in America, asked teachers to rate their knowledge and confidence in meeting the academic and social needs of children with 13 chronic medical conditions. The study highlighted the support offered for children who returned to school with chronic illnesses and found in self-ratings that teachers felt their confidence levels were not parallel to the ratings of their knowledge levels. Overall, teachers tended to have higher levels of confidence than reported knowledge about particular illnesses. The possible implications of Nabors et al's (2008) study could include further training for teachers so as to allow their knowledge base to become more closely matched to their confidence.

In terms of meeting the academic needs of these students, the only significant difference between special education and regular education teachers was in working with children with cerebral palsy. In addition, special education teachers reported significantly higher confidence in meeting the social needs of children with Spina Bifida and Cerebral Palsy when compared with regular education teachers. The reasons for these differences, however, are not so difficult to discern. It is quite likely that special education teachers in the sample had more classroom experience of working with children with cerebral palsy and Spina Bifida. This study was conducted in New York and has obvious implications for generalising the results to schools in the UK.

Mukherjee et al (2000), who researched the inclusion of children with chronic health needs, reported on a study which investigated the support needs of pupils in mainstream school with a chronic illness or physical disability. The research was carried out in three local education

authorities covering both rural and urban areas in England. In-depth, qualitative data was collected from 33 pupils in secondary school; 58 parents of primary and secondary school pupils; and 34 primary and secondary school teachers. Overall, the data from young people suggested variability in the support offered to pupils by teachers, even by teachers within the same school, and highlighted the importance of teachers' awareness and understanding of special health needs.

Conclusions of the research highlighted that individual differences in the type of support young people needed, and comparison of young people's and teachers' views, revealed differences in perceptions about how best to support pupils. This highlighted the importance of school staff and managers consulting young people, both when planning support for individuals and in more general service development.

Overall, the data suggests that support offered by teachers varies widely and there can be a number of reasons why this might be happening. Firstly, differences were reported in individual teachers' awareness and understanding of special health needs, even among teachers working within the same schools. These data are consistent with previous research with teachers, which finds a need for access to advice and information and a wish for improved direct liaison with health professionals (Court, 1994; Lynch *et al.*, 1992; Johnson *et al.*, 1988; Eiser and Town, 1987; Charlton *et al.*, 1986; Bradbury and Smith, 1983; Eiser, 1988). Furthermore, young people, parents, and teachers all had concerns about poor communication within and between schools, suggesting that improving communication and collaboration between health professionals and teachers would not be sufficient, and that communication between teachers and home-school communication also need to be improved.

This has important implications for future policy and good practice development, in particular focusing on whole school awareness/training on children with health needs, and therefore allowing for more suitable provision for children who may be reintegrated back into mainstream schools.

Research conducted in the USA by Shaw and Mccabe (2008), on various aspects of home to school transition for children with chronic medical needs, which includes surveys from young

people with chronic health needs, as well as documented research from professionals and mainstream schools, found the following key issues of importance when considering the topic of transition:

- The development of strong working relationships between school and health care systems. They suggested that transition planning is benefited when multidisciplinary teams are knowledgeable regarding the illness, treatment, and the potential effects of medications.
- Students should be viewed as individuals, as issues such as family factors, social support, and many others, mean that students with the exact same medical condition may respond and manage the condition differently.
- An evaluation of the transition program by professionals to ensure sudden changes in attendance, academic performance, or social adjustment can be addressed quickly.
- The voice of the child is important, as some children enjoy educating teachers and peers about their illness. However, others may wish to be treated no differently to their peers.

This research draws attention to important practices for transition or re-integration and can help inform planning for children who have had long term absences from school. However, the study does not discuss the emotional implications for children who remain out of touch with school for some time. Boulton (1997) comments on the need for continuity for children, something which is not often mentioned in the literature, and states that, in order to address children's emotional wellbeing, regular contact with their friends and school staff can ease the transition process.

Evaluation of WKHNES

The West Kent Health Needs Education Service (WKHNES) is a county-wide provision that sets out to provide continuity of education for pupils who are unable to attend their mainstream school. The mission statement defines the provision as a service that meets the educational needs of children who are ill or have suffered injury. They aim to take into account the varying medical, emotional, and social needs and support pupils in building their self-esteem and confidence by providing the stability of continuing education leading to successful re-integration back into mainstream school.

The service is provided for children aged 3-16 who fulfil the criteria, which includes children who have a statement for special education needs, children at home with health needs which prevent them from attending mainstream school for three weeks or more and children who are hospital in-patients.

WKHNES provide specialist provision for children with a variety of conditions, and currently includes a child with acquired brain injury, a child with Crohn's disease, and pupils with mental health difficulties such as agoraphobia /school phobia. All children who attend the provision due to their complex needs are considered to require intensive support to access education and meet their emotional needs. This also requires individualised education plans and regular communication between professionals and parents.

Staff members working within the service have many years of experience supporting children with medical and mental health needs. As part of their role they provide support to families as well as a graduated program back into education for the pupils. The staff members regularly liaise with professionals from CAMHS and the Health and Educational Welfare service (EWS). Ultimately the WKHNES works to deliver the five outcomes highlighted within the Every Child Matters (ECM) agenda (2005).

The WKHNES has clear policy and guidance and sets out key responsibilities for the home school within which a child is currently on roll and the health needs education service. Although the child remains on the register at the home school, the health needs education

service plays a large role in providing the child with education in the interim. The policy promotes the role of health and other services including post-16 support from Connexions in providing support and advice for pupils' educational opportunities.

Children who access the services at present have significant ongoing mental health difficulties as they all have ongoing involvement with CAMHS, which could either be a result of their illness/trauma or as a result of being out of the school community for a long period of time. The emotional impact in some cases has meant that home tuition is the first step to re-integration as even the small, structured environment of the health needs education services can create anxiety for the child.

Although the policy for this particular provision states that re-integration back into mainstream education is important aspects of the services, the number of children who are currently receiving provisions at the bases across Kent remain high, with few returning to mainstream schooling. Many of the children who remain in the services are children aged between 14-16 years.

Aims

The aim of this exploratory study was to identify some of the concerns which have made it difficult for children to be reintegrated back into mainstream school. This includes highlighting successful reintegration and good practice as well as looking in-depth at re-integration processes that have failed.

Methodology

As a researcher I wanted to collect data from the perspective of the participants. I believed this process would allow the participants to give their perceptions of the current concerns they have. This approach lends itself to a qualitative method of data collection. Approaching the exploratory study using a qualitative methodology suggested that the views of the participants were crucial to the data collection process. This is supported by a Social Constructivist stand point on research and data collection.

Methods

Interviews were seen as the most appropriate method of data collection because they would provide more in-depth information and allow participants to share information with the researcher in as much detail as they would want.

Semi-structured interviews were chosen as the method of data collection as this created some flexibility in the interview process but also offered a structured framework for all interviews. The semi-structured interview as a research tool is defined by Robson (1993 pg 228) as:

"A two-person conversation initiated by the interviewer for the specific purpose of obtaining research-relevant information, and focused by him on content specified by research objectives of systematic description, prediction, or explanation."

Robson (1993) describes interviews as serving three purposes. Firstly, as the principal means of gathering information having direct bearing on the research objectives. Tuckman (1972) describes interviews as a method of providing access to what is inside a person's head and gaining information relevant to the person using their own words, and thereby allowing the researcher to understand what a person thinks and values. Secondly, Robson (1993) states that interviews can provide information to test hypotheses or suggest causal relationships between variables. Thirdly, interviews may support methods of data collection in a research project. As a researcher, I wanted to gain information relevant to the person using their own words. Therefore, my aims fit most with semi-structured interviews.

The Interview questions were as follows:

- What are your views on the current re-integration process for children back into mainstream school?
- What do you see as positives and what are your views on things that could be developed further in regards to reintegration?

- Share your own experiences of the process of re-integration back into mainstream education.

WKHNES has three bases across Kent, and I focused on one base which had a number of pupils for whom re-integration into mainstream education had failed on at least one occasion. (For a full summary of the WKHNES please refer to appendix 1.) This base also had some children still under their care for over two years, when the policy highlighted that the provision for children should be for 6 months only.

The WKHES service has around 60 pupils on roll at present. Not all attend the provision as some are being tutored at home. The nature of needs include children with complex health needs such as severe physical injury, genetic disorders, one child who has cancer and three others with life-threatening conditions. About 80% of the pupils who are on roll at WKHNES have involvement with CAMHS in the form of regular psychiatric reviews and being on medication.

The participants were selected from the students who are currently attending the base on a part-time timetable. Participants were selected on the basis of availability. I wanted to discuss the process of re-integration so hoped to speak to pupils who had some experience of this at some point. Due to the different timetables of all pupils on the date I selected pupils who were available. Two staff members were interviewed, both of whom had lengthy experience of the service and had known many of the children who had accessed their service. Two interviews were conducted with pupils: one had been successfully reintegrated back into mainstream education and the other had experienced two failed attempts at reintegration.

Consent was gained from both pupils and their parents through a formal letter which is used by the Kent Educational Psychology Service (KEPS) when obtaining consent from parents and pupils. I also visited WKHNES before the conducting the interviews so that I could introduce myself to the teachers and pupils who may become involved in the interview process. To protect their identities the pupils names have been altered.

Procedure

The interviews were conducted at the WKHNES and lasted between 30-40 minutes. I utilised the semi-structured interview questions as prompts for myself and recorded the information given by participants onto a notebook.

Confidentiality was extended to all participants in the form that any information given would be available only to myself and to two tutors who would be marking my paper at the University. I explained that interviews would be anonymous and they could withdraw at any time during the interview.

Two pupils agreed to participate with interviews along with two professionals who work at the WKHNES base. One of the teachers was a home tutor and the other was a teacher who worked in the base to deliver curriculum subjects to children who attend the base on a daily basis.

Results

A thematic analysis was carried out of the interviews, thematic analysis is defined as:

"A method for identifying, analysing, and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail" (Braun and Clark 2006 pg 79).

Braun and Clark (2006) suggest that thematic analysis is widely used informally in the world of psychology research, but stated that there is no clear agreement about what thematic analysis is and how it is used. This approach to data analysis was chosen by the researchers because of its flexibility, as other data analysis such as grounded theory (GT) relies heavily on grounding the research findings to theory or phenomena about human nature. Due to the nature of the evaluation, the use of a GT analysis approach would have been a time consuming analysis and the small sample size would have limited the application of the results to the wider contexts which GT suggests.

The key issues/ themes identified by participants were drawn out of the interviews. Firstly, from the teachers' perspective, it was highlighted that the key issues which some children faced in re-integration include:

- Difficulties surrounding the inflexibility of some secondary schools. Some children find the environment within secondary schools daunting and can sometimes become overwhelmed.
- Lack of knowledge about a particular condition sometimes means that some children feel less able to share their concerns with school staff in the mainstream environment.
- Breakdown of communication between home and school, especially for some pupils who come from complex family backgrounds.
- Re-integration not happening at the pupils pace, as sometimes the pace of the mainstream environment becomes too much for children to cope with.
- Some children simply find it hard to adjust to a less nurturing and less controlled environment where one-to-one support is not always available when needed.

The teachers identified successful processes of re-integration and highlighted the key factors:

- Good communication with mainstream school through regular meetings and updates.
- Re-integration package has been very gradual, with flexibility in the timescale, and conducted at the pupil's own pace.
- Children who have been successfully re-integrated have maintained contact with key staff from the WKHNES and the staff feel that this link has helped to manage the children's anxieties through the knowledge that staff who know their difficulties are only a phone call away.
- Outreach services provided by the service to schools who have taken the children into their school.

Due to only having two pupils who agreed to being interviewed, a thematic analysis was not used instead a summary of the interviews is provided.

Views from Pupil A:

Child background: Pupil A is a 14 year old male who is currently attending the WKHNES base since January 2008. He is still on roll at his secondary school and took time off in Year 7 due to his physical injury and now would have been in Year 9 since September 2008.

A is a Child who is still at the WKHNES after being out of school for two years due to a physical injury and social anxiety. Through the interview conducted with A, he stated that he was not able to rejoin his peers in mainstream school as he did not feel comfortable due to the length of his absence (two years). He stated that he now worried about how peers would react to him and whether he would be able to established positive peer groups. He also stated that he had been bullied in the past and fears remained around this issue reoccurring.

He discussed that he did not feel that the re-integration package was always something he felt comfortable with – for the re-integration process offered by WKHNES (please see appendix 1 pg 12). He felt that, although he was comfortable with the planning, his concerns remained in regards to how things would be for him once he began to attend mainstream school. He had concerns about his attendance and his anxiety, and remained worried about how school staff in the secondary environment would deal with his difficulties.

He stated that he would feel a lot more comfortable in a small environment and, although he was being supported by CAMHS through one to one therapy sessions with a Clinical Psychologist, he did not want to lose all contact with the staff at the base. It became clear from our discussions that the small nurturing environment at the base was something pupil A did not want to lose.

Pupil A stated that he felt that a part time placement in a mainstream school for some subjects would be less stressful for him and the rest of his time he would continue to spend in the base unit.

Views from Pupil B:

Child background: Child B is a female aged 15 and has been out of school for over a year. Her main concerns were regarding her social communication difficulties, particularly anxiety within certain social situations. She was diagnosed with Autism and after some time stopped attending school through fear of bullying and general anxiety regarding school.

Child B has severe autism and complex social needs, and is now successfully reintegrated into mainstream school. She stated that she found the re-integration process positive as the staff in the mainstream school had a lot of knowledge about her difficulties and she attended the school for six months on a part-time curriculum. She stated that this worked for her as it gave her and the school the opportunity to build a relationship.

She stated that the school became aware of her difficulties and supported her through regular meetings with the family. She also stated that having contact with staff from the base, even though she had moved to mainstream school, gave her confidence and eased any anxieties that she had.

Discussion

The results obtained highlighted a number of common themes, which include the need for continuity, communication with the mainstream school and contact with the base unit once the children returned to mainstream school. These themes were also supported by the research literature highlighted previously. It has particular similarities with the work of Shaw and McCabe (2008), which also highlighted the need for communication and careful planning from teachers and health professionals.

Overall, the themes raised within this evaluation indicate the importance of careful planning and engagement of the pupil into the re-integration process for it to be successful. However, it can also be stated that for some children the small nurturing environment provided by the small provisions, such as WKHNES, give children the opportunity to have access to education and socialisation if, due to their difficulties, they are for many different reasons unable to attend mainstream settings.

The limitations of this evaluation are associated with the lack of data available from other professionals who liaised with the provision, and the views of the parents of children who still remain on home tuition. Although the interview process enabled me to gain some information from the perspective of staff and pupils, this only gave a snapshot of the complexity of the re-integration process. Due to the unavailability of a larger sample of pupils on the day of the interviews the results were limited and not generalisable to the population of children with medical needs.

One theme raised by the staff from the WKHENS that were interviewed was the need for regular communication between professionals. This information is consistent with much of the research identified in the literature review. For example, Farrell and Harris (2003) highlighted this as an area of good practice, Asprey and Nash (2006) stated communication with professionals as important from the point of view of parents and children whilst Poursanidou et al, (2008) suggested a more proactive and preventative approach would be beneficial in meeting the educational needs of this group.

Another theme raised from the interviews conducted with the two pupils was the feeling of being supported and their needs being understood by the mainstream environment. These findings are also supported by the studies conducted by researchers such as Mukerhjee (2000), Nabors et al (2008) and Shaw and Mccabe (2008). All of whom state that awareness and staff training can support the re-integration of children with long term medical, or mental health concerns.

However, there are still some areas that can be addressed through further research in this area. Much of the research has been qualitative, which is open to researcher interpretation, and researchers such as Boulton (1997) and Farrell and Harris (2003) conducted their research some time ago. Current research is limited and definitions of what is classed as medical needs and mental health concerns is varied across different researchers.

Conclusion

This paper explored the historic and current legislation and policy relating to children with medical needs in the UK, and how this impacted on their access to education. An explorative study was conducted to highlight the complexities in supporting this group of children with their re-integration into mainstream provision after a period of absence from school or being placed into Hospital Schools.

The research highlights the current good practices from some LA's, and areas that still need to be developed such as the communication between health and educational professionals, the voice of the child and support for the families of these children. The results of this evaluation confirm the in regards to listening to the needs of the children involved and providing a transition package which works at the pace of the child involved.

In this paper I have tried to highlight the need for further research into this area due to the lack of data about the mental health concerns for this group of pupils. The research and evidence from WKHENS suggests that, although the medical needs are addressed, the emotional well being of children who lose touch with school routine and friendships should also be addressed, which has not been clear in the research. Another further implication of this paper is the recommendation for professional development for staff who work with children who have medical needs, as the needs vary from pupil to pupil.

The research has a number of implications for the practice of Educational Psychologists. For example, supporting schools in capacity building through the process of understanding the complex needs of this group of children. Working with hospital schools and professionals from CAMHS and other agencies to help support re-integration and provide a more holistic view of the child's difficulties. Educational Psychologists could also provide a vital role in facilitating a forum for the voice of the children who are out of school on a frequent basis for many different reasons, which is an area where the research is still very limited.

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APPENDICES

Appendix 1

1. Introduction

Local Education Authorities have a duty set out in the Education Act 1996 to:

Make arrangements for the provision of suitable full-time or part-time education otherwise than at school for those children of compulsory school age who, by reason of illness, exclusion from school or otherwise, may not for any period receive suitable education unless such arrangements are made for them.

A similar duty applies to young people not of compulsory school age.

Kent County Council is committed to ensuring that, children and young people absent from school for medical reasons have access to a full and varied curriculum throughout the period of their illness. Kent County Council is also committed to working with schools and health colleagues to ensure that children in Kent who are ill are supported in achieving the five outcomes set out in the Children's Bill and that their illness does not prevent them from reaching their full potential. The five outcomes are :

- being healthy
- staying safe
- enjoying and achieving
- making a positive contribution
- economic well-being

Provision will be made for each child to receive a package of quality education and support suited to their particular needs and medical condition. This policy sets out clearly how this commitment will be met and by whom. . All schools should include a summary of this information or a reference to the policy in their prospectus.

The pupils are covered by this policy are those with:

1. unexpected acute illness such as accident, a range of physical complaints: cancer, heart disease, liver and bowel and bone disorders;
2. recurrent conditions such as diabetes, asthma, serious allergies and metabolic disorders;
3. congenital disorders such as haemophilia and cystic fibrosis;
4. mental health related problems manifest in eating disorders, school phobia/school anxiety disorder, acute anxiety and depression
5. ME (Chronic fatigue Syndrome) which is on the increase and is frequently undiagnosed
6. And illness or enforced rest related to pregnancy

The named Kent LEA senior officer with overall responsibility for the provision of education for children or young people who are unable to attend school because of medical needs is Joanna Wainwright, Assistant Director for Pupil Services.

2. How responsibility for provision is shared between the home school, the LEA service for children with medical needs and the health agency

Kent County Council considers that the well-being and education of pupils who are physically ill, injured or who have mental health problems is the responsibility of the schools and services. The Home school has a vital role to play in ensuring children who are ill have the support they need to maintain their education. The LEA service has a vital role in resourcing, delivering and monitoring the specialist provision required during their illness. The health agency has a vital role in liasing closely with the education staff to ensure that the planned provision is appropriate and that all the needs of the child, health, social, education and emotional are being addressed.

The Home School[1]

The Home school will

- Produce a written policy and establish practical procedures showing clearly how the school will support children with medical and mental health needs by making those appropriate arrangements for educational provision[2] and working with all those involved in the child's life to ensure that they achieve the five outcomes set out in the introduction to this policy
- Monitor pupil attendance and mark registers so that they show if a pupil is, or ought to be, receiving education otherwise than at school
- Establish appropriate management structures, staff responsibilities and lines of communication within the school for pupils with medical needs
- Identify a named contact within the school with overall responsibility for the provision of education and support to children with medical needs
- Ensure that pupils with statements of special education needs who cannot attend school for medical reasons continue to receive the support outlined in their statement for example additional support learning time, access to other LEA specialist services. Responsibility for providing this support will lie within the home school.
- Set out clearly how the school's procedures will take account of pupil's views
- Establish procedures in line with guidance from the LEA laid out in this policy for ensuring that pupils are reintegrated smoothly into the school, when the time is right for the pupil.
- Set out clearly how the school will liase with parents and carers

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[1] The Home School refers to the mainstream school, special school or resourced mainstream provision in which the child is on roll

[2] Policies and procedures will be drawn up with reference to the Department of Education and Skills guidance for Head teachers, Local Authorities and Governors issued in November 2001, entitled Access to Education for children and young people with medical needs.

- Review the school's policy and procedures each year, revise as necessa and use as a tool for improving provision

In the case of each child absent from school for medical reasons,

- Notify the Health Needs Education Service Coordinator as soon as it becomes apparent that the child will be absent for more than 15 days due to illness. This notification should be copied to the cluster based education welfare officer.
- Liase with the health professionals responsible for the child and ensure that a referral is made to the HNES with all the necessary information
- Follow the procedures for referral set out in section 4 of this document

As soon as admission to the HNES has been agreed,

- Provide assessment information and curriculum plans to inform the planning of educational provision and support at the outset and on a regular basis in cases of pupils with long term or recurrent illness
- Identify a named staff member who will act as contact point and aid communication with the HNES, the relevant health professional, the parent/carer and the pupil
- Provide work and materials for the pupil as required
- Liase with the named staff member or tutor from the HNES to jointly draw up a Personal Education plan (PEP) to cover the complete education for the child from day one of absence through to reintegration to the home school
- The PEP should be agreed with the appropriate Health professional that is, the, hospital staff member or consultant responsible for the child's medical diagnosis
- Set and attend regular review dates to assess progress and encourage reintegration

The HNES for children and young people with medical needs[3]

The HNES – East and West Kent will

- Ensure that pupils receive an education complementary and/or comparable to that available in schools, including a broad and balanced curriculum where physical needs allow
- Work closely with all those involved in the child's life to ensure that they achieve the five outcomes set in the introduction to this policy
- Maintain an effective tracking system to ensure that children with medical needs are not out of school without access to education for more than 15 working days
- Ensure that children who have an illness/diagnosis which indicates prolonged or recurring periods of absence from school, whether at home

[3] The HNES for children with medical needs within the current organisational structure refers to the centrally managed services of the HNES Bases at East Kent, West Kent and Gatland House.

or in hospital have access to education, so far as possible, from day one of their absence.

- Ensure that pupils with medical needs educated at home receive a minimum entitlement of 5 hours teaching per week, with take-up depending on medical advice and their views and those of their parents
- Have a written admission policy with clearly defined admission criteria and exit strategies for pupils accessing their service
- Make available up to date information for schools, parents, children & young people and health professionals on the service and how it can be accessed

In the case of each child absent from school for medical reasons,

- Follow the procedures on referral detailed in Section 4 of this policy
- Ensure that an individually tailored Personal Education Plan is in place for all children absent from school for medical reasons
- Ensure that the PEP is agreed with the appropriate Health professional that is, hospital staff member or consultant responsible for the child's health
- Teach pupils in accordance with their Personal Education Plan

The Personal Education Plan will include:

1. *The Education plan for the period of absence including curriculum to be covered and type of tuition suitable at each stage of the absence i.e. hospital ward tuition, home tuition and/or hospital school placement*
2. *Name of the Key worker responsible for ensuring that the PEP is implemented in full*
3. *Dates and details of regular review meetings to monitor progress of the child and to discuss potential reintegration*
4. *Views of the child and parent/carer*
5. *Responsibilities of all those involved in the delivery of the pupils education and support package*
6. *Agreed reintegration plan*

The centrally managed HNES will

- Review this policy and all procedures for the education of children with medical needs each year, revise as necessary and use this policy as a tool for improving provision
- Set out clearly how the views of children and families are taken into account in the planning and provision of education for children with medical needs. This is covered in Section 5 of this policy
- Monitor the quality of provision in all parts of HNES including home tuition, hospital ward tuition and day unit placements. The quality of educational provision within the service will be further monitored through the Ofsted inspection process
- Establish robust management, organisational and budget structures which facilitate rapid response to pupil's needs and efficient resourcing across all parts of the service

The Health agency[4]

The health professional will

- Ensure that a holistic approach is taken to the welfare of the child by facilitating timely access to appropriate advice and to effective services which address their health, social, education and emotional needs throughout the period of their illness
- Work closely with all those involved in the child's life to ensure that they achieve the five outcomes set out in the introduction to this policy
- Establish clear procedures for staff which enable children who are in their care to participate in education
- Make arrangements at a strategic level for co-operation and planning between the health agency and the education service
- Have agreed protocols for sharing information about children who are ill between the health agency and the education service
- Make necessary arrangements for publicising education provision in the county for children who are ill
- Once educational provision has been agreed, make arrangements for a health professional to participate in multi-agency meetings to plan and monitor the child's education and reintegration into school

In some cases, the nature of a child's illness is unclear. Mental health problems in particular can involve frequent or long absence from school. A mental health condition may for example manifest itself in truancy, school refusal or disruptive behaviour. Medical needs of this kind include conduct or hyperactivity disorders, emotional disorders such as depression, anxiety and in some cases psychosis. In such cases, mental health professionals will

- Make every effort to provide the medical evidence necessary for the child to secure eligibility for educational support as quickly as possible
- Liaise closely with the child's home school and the hospital school service throughout the referral process to ensure that a child is not left without education for longer than the statutory period of 15 days

3. Kent specialist provision for children and young people with medical needs

Specialist provision for children covered by this policy is made through the HNES, which manages school, group and home tuition from two bases, one in East Kent and one in West Kent, as well as providing education on hospital wards with Gatland House Education Unit serving the needs of tier 4 inpatients at the Oast in Maidstone. Procedure for accessing the service is covered in section 4 of this document. The service offers the following provision –

[4] The health agency refers to the agency with primary responsibility for addressing the child's health needs. This could be the consultant, psychiatrist, CAMHS professional or hospital staff member caring for the child during their illness.

Hospital ward teaching

Pupils are eligible for hospital ward teaching when they are expected to be in hospital for 5 days or more, subject to their medical condition. Pupils with recurrent admissions are taught from the first day, where possible. Hospital teachers will design specific work programmes outlined in the Personal Education Plan, in the context of the National Curriculum, which represent worthwhile educational experiences but which can be completed in short periods. Teaching is provided on the wards. Teaching sessions are scheduled as appropriate, subject to the child's medical condition.

Home tuition

Pupils absent from school because of medical needs will have access to home tuition within 15 working days. If a pupil is likely to return to school within 15 days, the home school will be responsible for any provision of work required. If there is prolonged, or recurring absence from school, the pupil will have access to home tuition, as far as possible, from day one. Home tutors are contracted and managed by the Hospital School Service in the area in which they work. Reintegration to schools is facilitated immediately when a child becomes well enough to attend school, or gradually when a home tutor teaches for a limited period in the school or both school and home tuition are maintained for some time.

Day unit placement

The HNES in West and East Kent provide unit placements on three sites –

West Kent HNES

- Raynehurst School ,Gravesend
- Tonbridge Unit, Oakley School, Tonbridge
- Tunbridge Wells Satellite, Seal Satellite

East Kent HNES

- City View, Canterbury,

Gatland Education Unit

- Gatland House, Maidstone

These units provide a safe and protective environment for children with a range of medical needs. Provision is made at these units for pupils to attend for short placements as part of the process of reintegration back into their mainstream school. Provision is also made for pupils with long term or recurring illnesses who cannot attend mainstream school due to their condition but will benefit from social interaction of a school environment.

Maidstone Adolescent Unit (Gatland House)

This specialist unit is run by the Invicta Trust and has residential accommodation for 8 pupils with 2 further emergency beds for secondary

aged pupils. Teaching support is provided through the LEA Attendance and Behaviour Service. The Unit provides

- Assessment and treatment of children, adolescents and their family/carers who are experiencing psychological, developmental, behavioural and interpersonal difficulties
- Assessment and treatment of children and adolescents who are presenting with definable childhood and adolescent psychiatric disorders.

The teaching unit aims to provide a small therapeutic environment and positive experience of education, which builds pupils' self esteem, enabling them to experiment with different strategies for their recovery. It also aims to develop patterns of behaviour and attendance that will make it possible for them to return to mainstream education with the support of their parents/carers. Referrals are made to the HNES Coordinator by the home school.

ICT

ICT will play an increasingly important part in ensuring the quality and continuity of out-of-school education. Kent LEA and schools will increasingly use CD-ROMs, e-mail and the Internet to extend the variety of educational materials available to children and young people with medical needs and their teachers. Standards fund allocations have been used to develop distance learning using as approach known as the "virtual classroom". All pupils with medical needs have access to ICT educational provision of this kind.

The Curriculum and Public examinations

Unless there are very good reasons otherwise, the Hospital School Service will ensure that pupils have access to the full National Curriculum and public examinations at the appropriate age. As a minimum, pupils are entitled to a broad and balanced curriculum complementary and comparable to that in schools. How and when they are able to access this will depend, of course, on their medical condition.

Arrangements for sitting examinations will form part of the pupil's Personal Education Plan. Awarding bodies may make special arrangements for pupils who are ill, taking public examinations, such as GCSE's or A levels. The named key worker within the PEP should submit applications for special arrangements to the awarding bodies as early as possible.

Long-term patients

Teaching whether in hospital, at home or at hospital school will continue for any child with a life-threatening chronic or degenerative condition for as long as they feel able to access this. Arrangements to undertake examinations will proceed as for any other pupil. Pupils with a variety of progressive or degenerative medical conditions may require special consideration when educational support or intervention is considered. In particular the HNES makes arrangements for

- Maintaining educational input, even when a condition is progressing rapidly

- Close contact and involvement of the parent/carer in the planning and provision of education for the child
- More frequent and regular reviews of the child's education and support plan to ensure that all of their needs are being met.
- Close liaison with health professionals to ensure that the child's well being is considered above all else, particularly where medications and medical equipment are provided
- Rapid response from agencies contributing to SEN statutory assessment in cases where a statement is required

Post-16 transition

A young person's educational needs post-16 may require additional consideration, particularly where he or she has made slow progress up to the age of 16 because of interruptions in their education due to illness. All agencies try to enable a pupil to continue any course of study being taken on entry to hospital or whilst ill or injured at home.

The HNES will normally arrange continuing education for a young person over compulsory school age but under 18 where, because of illness, he or she will need to study for a further year to complete examination courses. Where a young person has a Connexions personal adviser, they will play a key role in co-ordinating delivery of the Transition Plan and in helping to identify and co-ordinate access to appropriate post-16 provision. Further details on how the education service collaborate with the Connexions service in such cases is dealt with in Section 6 of this document.

Transport

The provision of transport to and from school by the LEA can sometimes enable a pupil to readapt to school. Kent LEA, however, is only under a statutory duty to provide a transport if the nearest suitable school is not within statutory walking distance of the child's home by the nearest available route. Otherwise the provision of transport is at the LEA's discretion. If a child is attending a Health Needs Education base or grouped/satellite tuition, transport is provided. It is recognised that it is generally more cost effective and educationally and socially sound for children to be transported to a centre for tuition or to the home school, rather than to provide tuition at home.

4. How to access the HNES

Referrals for children and young people with medical needs are routed directly through the HNES for the area in which the child lives and are authorised by the HNES Headteacher in most cases. Standard referral forms are available from the HNES Coordinator and on clusterweb. The pupils considered will be those outlined in the "Introduction" of this document. Referrals to the service can be divided into three categories for the purposes of this process

Cases in which the nature of the pupil's illness is clear and the package of education support required can be set up immediately. The following steps will be taken:

a Referral form completed by home school in liaison with the relevant health professional and forwarded to the Co-ordinator at Sessions House
b Contact with the Family, Hospital and Home school made by the Head teacher of the East or West Base or Gatland Education
c Arrangements are made for the most suitable package of provision – home tuition, hospital tuition and/or tuition at a base or satellite
d Personal Education Plan is drawn up jointly by the named staff member at the home school and the named staff member or tutor within HNES

Cases in which the nature of the child's illness is more complex and where the involvement of a multi-agency panel in decision-making is seen as beneficial. These cases are often those of pupils with mental health-related problems. The following steps will be taken.

a Referral form completed by the home school in liaison with the relevant health professional and sent to the HNES Co-ordinator
b Contact made with Family, School and Health professionals by the Head teacher
c No obvious support package identified therefore case forwarded to the District Inclusion Forum (DIF) or CBR for multi-agency consideration
d In cases where at the outset, there is doubt as to whether the child is a suitable referral for the HNES, a referral form can be sent directly to DIF for multi-agency consideration.
e The Senior Inclusion Coordinator operating across two districts will through DIF chair discussion across agencies and seek to identify a suitable placement for the child.
f The resulting action plan will be co-ordinated through a key worker from the predominant service
g Details of the referral and support package are recorded on the DIF or CBR database

Cases where a child is out of school for what is perceived to be medical reasons and is not on the roll of a school. The following steps will be taken:

a Referral form completed by the parent or health professional and sent to HNES
b Referral to admissions and ACM

Contact details

East Kent Health Needs Education Service
Ros Eastwood. Tel: 012227 781548

West Kent Health Needs Education Service
Graham Taylor. Tel: 01474 365467

Gatland Education Unit
Julia Coles. Tel: 01622 693000

5 Partnership with parents and carers and pupils

It is recognised that parents and carers have a key role to play in their child's education and have valuable expertise and knowledge, which will ensure their child's well being and the continuity of their education during the period of their illness. They will be full partners in the drawing up of their child's personal education plan and will be fully informed about their progress at all times. Children and young people, will also be fully involved in making decisions and exercising choices.

Wherever possible, parents carers and pupils are informed about the education available before a child is admitted to hospital. Leaflets are available to provide information about educational and medical services. The Kent Partnership with Parents service is available to all parents who need support during this difficult time[5].

All parents and carers are consulted before teaching begins at home and offered advice and support during the pupil's illness. Parents and carers are encouraged to liase with the pupil's home school, both at the beginning and end of a stay in hospital and with the home tutor. The positive involvement of parents with the school once the child has returned to school provides reassurance for the child, teachers and parents themselves.

In the case of a child or young person in public care Kent County Council, as the corporate parent, is responsible for safeguarding and promoting his/her welfare and education. The authority and primary care users (foster carers or residential social workers) hold valuable information about the educational achievements of the children and young people in their care. They will play the same key role to play in the planning and implementation of the child's Personal Education Plan as any other parent.

6 The role of other services and agencies

Effective and flexible collaboration of all those involved in educating and supporting the child through their illness is crucial to the continuity of high quality educational provision for children and young people with medical needs and successful re-integration into school. Whilst the responsibilities of the key agencies are set out in section 2 of this document, this section covers the role of other professionals that may be involved at different stages of the child's illness.

Education Welfare Officers (Attendance and Behaviour Service)
Education Welfare Officer (EWOs) play a key role in resolving attendance issues, importantly that of identification of attendance problems related to medical issues. EWOs employ a variety of strategies including a school referral system, home visiting and working with other agencies. Each cluster of schools ahs a named EWO to work alongside the designated member of school staff to co-ordinate a response to poor attendance as a part of a whole school approach to inclusion. Shared policy and operational practise between

[5] The Partnership with Parents helpline 01622 755515

the Education Welfare Service, the Health Needs Education Service and schools is vital. EWOs will work with school to ensure registers are checked and contact is made with a child's parents or carers promptly on the first day of the absence.

Connexions
The Connexions Service provides information, guidance, referral and support for all young people aged 13 to 19 in England, including giving more in-depth support to those who are at greatest risk of not making a successful transition to adulthood. The service will therefore play a key role in supporting children with medical needs who need some extra guidance or mentoring at various stages either throughout their illness or as they decide on their future path after school.

The personal adviser, working closely with the home school, will need to assess the young person's needs and in some cases help broker access to, and monitor the support given by, the HNES or any other specialist service. The service provides a link Personal Adviser to each of the HNES Bases. The HNES will notify the Connexions Service of all young people with medical needs, aged 13+. The link Personal Adviser will ensure that young people with medical needs have access to a Connexions Personal Adviser either at the school, college they are attending or within the home area, if not attending a school.

7 Ensuring successful reintegration into mainstream school

Returning to school after a period of absence can be an emotional hurdle for a pupil. Friendships can be damaged by a long absence. Peer group contact during an absence, for example cards, letters, videos and invitations to school events, are as important as formal contact. The Home School needs to develop a welcoming environment and encourage pupils and staff to be as positive and proactive as possible during the transition period. Consultation with the child and parents and key staff about concerns, medical issues, timing and pace of return is important.

A strategy for re-integration will be a key element of the child's Personal Education Plan developed jointly by the staff member within the HNES Base and the child's home school. The re-integration strategy should include

- Date for planned reintegration
- Details of regular meetings to discuss reintegration
- Clearly stated responsibilities and rights of all those involved
- Details of social contacts including the involvement of peers and mentors during the transition period
- A programme of small goals leading up to reintegration
- Follow up procedures

8 Budget, organisation and staffing[6]

[6] This section represents the budget and organisation of the HNES as it currently is.

Budget
Kent receives funding through its standard spending assessment enabling the required resources to be delegated annually to the HNES to cover the running costs of the main bases and the costs of the home / hospital tuition. Mainstream schools' recurrent funding is based on their pupil numbers on the second Thursday in January. With certain limited exceptions relating to pupils in nursery or SEN units, all pupils on register on the day of count (including pupils absent on grounds of sickness) will be included in the count. This funding is used to resource the delivery of the Home School's responsibilities to children on their roll who are absent due to illness.

Organisation
Kent LA's service for children and young people with medical needs was established in 1996 to manage and develop the work of existing Hospital and Home teachers around the county. The service is co-ordinated from two administrative bases in east and West Kent. The management groups and Head teachers of the two services are responsible within their area for-

- Provision planning
- Budget management
- Day to day operational issues
- Staffing
- Monitoring and Evaluation
- Quality and standards

Staffing
The HNES Base teachers and tutors working in day units, children's homes or hospitals are employed by the HNES Base within their area. They are subject to the same recruitment process and checks teachers in any other school. Continuing professional development is particularly important for teachers of pupils with medical needs. They have responsibility for teaching all ages and all abilities. They also have a key responsibility in dealing with other agencies. Kent LEA will ensure that teachers in home and hospital teaching services have access to continuing professional development in the same way as other teachers and assistants.

HNES teachers are encouraged to liase and share good practise with other teachers of pupils with medical needs. Opportunities will be considered for training health, social services and education professionals together, to facilitate the development of multi-disciplinary teams to work across traditional boundaries and to promote multi-skilling.

9 Priorities for development

In order to meet its statutory responsibilities for sick children, Kent LA proposes to:

- Review the current provision
- Consult and plan for the devolution of the service

PROFESSIONAL PRACTICE REPORT TWO

Investigating the evidence base of Social Stories as an intervention to support a child with Autism: Implications for Educational Psychology Practice

Abstract

This paper seeks to explore the effectiveness of social stories as an intervention for a child who has a diagnosis of Autism. This specific intervention was chosen by the author to explore in more detail due to its relation to a case example that the author was involved in during her role as a Trainee Educational Psychologist (TEP).

The paper is separated into three sections; the first section gives an overview of the above mentioned case example, a Primary aged male, who was diagnosed with Autism. He was referred to the Educational Psychology service by the school in collaboration with his parents. The TEP's involvement began from this point. An assessment of his needs is summarised using the Problem analysis framework designed by Monsen, Graham, Frederickson, and Cameron (1998).

Secondly the paper looks into the theoretical underpinnings of Autism and how this presents itself in young children. This information will help to link the theory of Autism Spectrum Disorder (ASD) as the author feels that having a greater understanding of the psychological theory regarding ASD is important to support the children's needs. This section will also identify some of the many interventions that are currently available for schools and parents to help manage difficulties faced by this group of children.

Finally the third section of the paper will focus on a research overview of the social stories intervention; the rationale for why this intervention was chosen by the author includes its possible use with the case study in which she was involved. The evidence base of this intervention will be explored and how this impact upon her work as an Educational Psychologist will also be discussed.

Case overview

EH was diagnosed with Autism Spectrum Disorder (ASD) in January 2009 and, as part of the strategies agreed with the primary school, staff were to set up some social skills work to support EH's understanding of social situations and how to respond appropriately to them. One of the key concerns for EH's family and the school included his anxiety regarding secondary school transfer. A number of suggestions were explored with the school SENCo, one of which included using a social stories intervention. The recommendation to use a picture social story about his secondary school was suggested by the TEP and agreed with by the school SENCo who had used this method to support a pupil with similar difficulties as EH. However, the TEP was unsure whether social stories were an appropriate intervention for EH. On further exploration it became clear that there were a number of possible interventions. For example of Circle of Friends (discussed in section one) which was not feasible in this instance because of the time scales between the end of the school term and the time a Circle of Friends intervention would take to set up.

The TEP felt that social stories were an intervention that she had limited experience in. Therefore to support the SENCo in making an informed choice she decided to investigate what the research suggested about social stories intervention and whether there was a strong evidence base for this approach to teaching children appropriate skills to manage difficult social situations.

The TEP also took this opportunity to understand in more detail EH's difficulties linked to his diagnosis of ASD. Therefore, this next section focuses in more detail on ASD and research relating to the evidence base for social stories interventions. This process helped to inform the author's thinking regarding suitable interventions for children with ASD which she would be able to take further in her professional practice.

Introduction to Autism Spectrum Disorder

People with Autism have said that the world, to them, is a mass of people, places, and events which they struggle to make sense of, and which can cause them considerable anxiety. In particular, understanding and relating to other people, and taking part in everyday family and social life may be harder for them. Other people appear to know, intuitively, how to communicate and interact with each other, and some people with Autism may wonder why they are "different to the world around them" (National Autistic Society, 2009).

Autism is a lifelong developmental difficulty and is widely known as Autism Spectrum Disorder (ASD). People who are diagnosed with Autism are often described as being on the Autism Spectrum and are sometimes referred as having ASD (Autism Spectrum Disorder). The word "spectrum" is used because, although all people with Autism share three main areas of difficulty, their condition will affect them in different ways. It can be stated that characteristics linked to ASD present themselves differently in all individuals. Some people are able to live their everyday lives relatively independently, whereas others will require a high level of support throughout their lives.

"Autism is a lifelong developmental disability and is not defined by any particular behaviour but a set of behaviours on a continuum. It is therefore known as a Spectrum Disorder because it affects individuals differently and to varying degrees" (The National Autistic Society, 2009).

The most commonly citied term for describing the difficulties faced by children on the Autism Spectrum was provided by Wing and Gould (1978) who identified a Triad of Impairments. This states that children who are diagnosed with ASD have 3 common areas of difficulties which are as follows:

- Difficulties in social relationships
- Difficulties in social communication
- Difficulties in social imagination.

A description of the Triad of Impairments is provided in figure 1below:

Figure 1

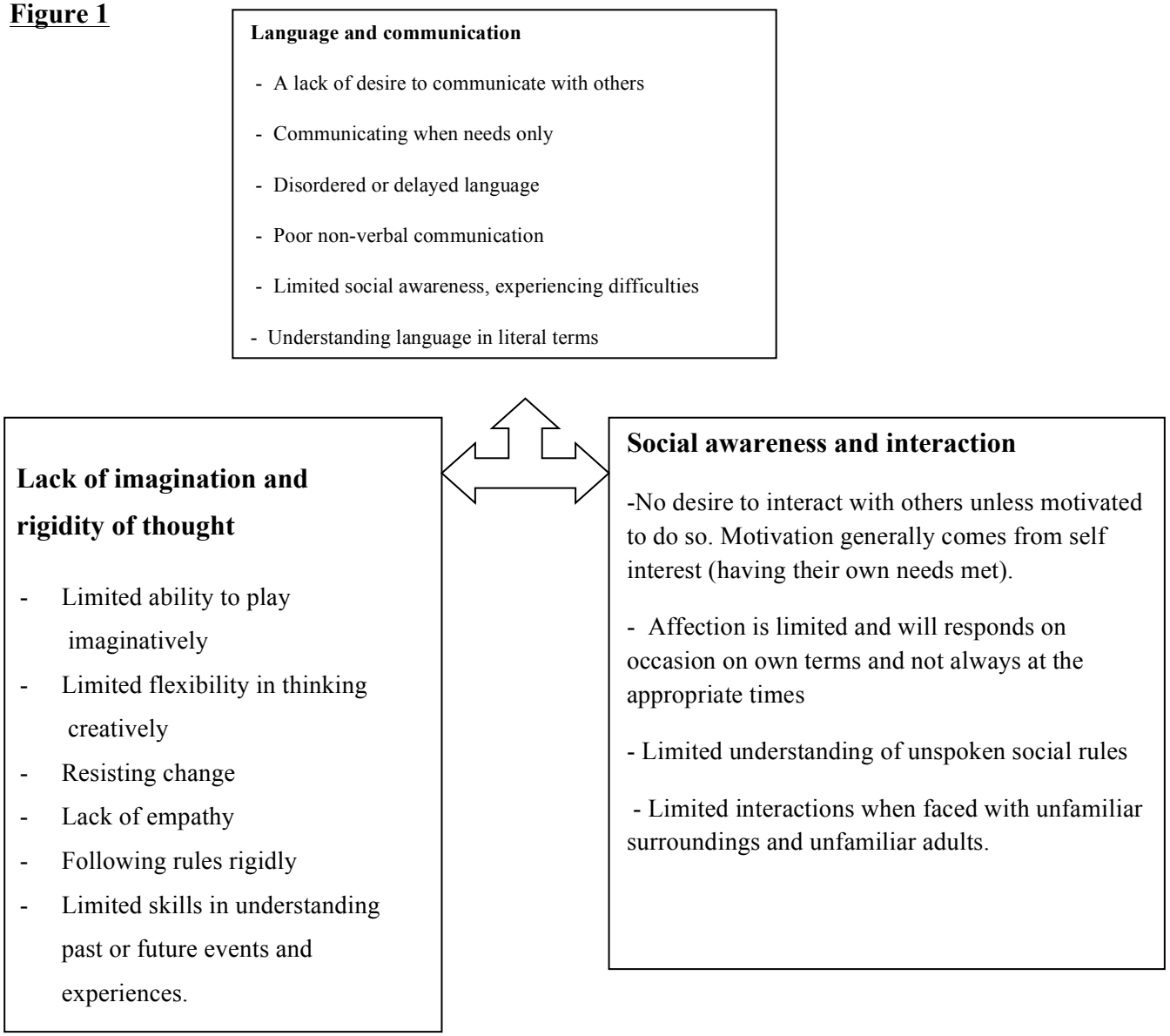

Figure 1: Triad of impairments (adapted from Hannah 2001 in Ali and Frederickson 2006, p.356).

The above figure (1) describes the three areas of impairments which can be experienced to varying degrees by children who have ASD. These impairments are not necessarily displayed in any visible physical disability. Therefore, children with ASD can often be viewed as children who are experiencing behavioural difficulties.

The three areas affected include non-verbal and verbal communication. Children with ASD not only have difficulties understanding the communication of others but also developing effective communication themselves. Many children experience a delay with speech and language development. Therefore, they may require the teaching of other means of communication, such as using pictures, photos, gestures and written words (Jordan, 2002).

Social understanding is the second of the triad of impairments discussed. This also includes socially accepted behaviours which pose a challenge for children with ASD, as their difficulty in understanding social norms and rules can lead them to do things which may not be seen as appropriate by others. Children with ASD are very literal thinkers and interpret language without being able to read the more subtle social context (Howlin 2008).

Thinking and behaving flexibly is the third component within the triad of impairments. This means that children with ASD often find it hard to see toys in different ways other then them being conventional objects to play with. For example, fixating on a particular aspect of a toy i.e. it's colour or if it flashes and makes a noise, children with ASD can often play with this one toy or aspect of a toy for long periods of time with intense concentration. Their play is often isolated; they may play alongside other children but even then may not necessarily be aware of the presence of others (Ali and Fredrickson, 2006).

In relation to EH and the Triad of Impairments from observations of his behaviour and information from the class teacher and his parents particular difficulties for EH were linked to social communication and rigidity in thinking processes. This including finding it hard to initiate interactions, understanding appropriate social interactions and being unaware of what to do in unfamiliar situations.

Due to the nature of these difficulties, often new skills are challenging for children in this group to generalise to different social contexts. Therefore, they may require specific help such as explicit understanding of social situations and learning to generalise the skill to different contexts. For example for EH the transition to secondary school required careful planning and explicit explanations so that he was able to understand what to expect when he attends in September. The skills he had learnt during his time at the primary school were hard for him to generalise and adapt to the secondary school environment.

A fourth aspect which can be a characteristic of children who have ASD includes difficulties in sensory perception and responses. There is some evidence that suggests that some children with ASD are overly sensitive or under sensitive to certain noises, smells and textures. This has implications for the home and educational environments for these children and may impact on how they respond to certain activities at school and in the home (Jordan 2002).

Frith (1992) highlighted the importance of understanding that Autism arises as a consequences of the interactions between one or more of the above impairments. The degree to which an individual is affected by each of the three impairments can vary significantly.

Further understanding of the impairments associated with ASD can be explored through the three main theories of ASD as identified by Baron-Cohen (2003 pg, 33). These include the Theory of Mind (TOM), The Central Coherence theory and the Executive Function.

The Theory of Mind (TOM) suggests that ASD children have a rigid thought process which prevents them from understanding another person's viewpoint (Jordan 1999). Theory of Mind focuses on explaining social interaction and communication difficulties.

In summary, TOM can be described as the ability to appreciate that other people have mental states intentions, needs, desires and beliefs - which may be different to our own. Baron-Cohen and Bolton (1993), Baron-Cohen (2003) and Frith (1992) proposed that individuals with Autism lack a Theory of Mind. Baron-Cohen (2003) went on to describe this as a form of "Mind Blindness" on the basis that mental states are not visible and therefore have to be hypothesised. Baron-Cohen, Frith, and Leslie (1985) tested children with varying difficulties and disabilities using the "Sally Anne–Test" which is a practical demonstration of children's ability to understand others' thoughts. The results highlighted those children with ASD type characteristics were unable to answer the hypothetical question "where will Sally look for her ball".

The Central Coherence theory describes the difficulties associated with planning and organisation skills, attention and impulsivity which are often linked to children with autism (Baron-Cohen, 2003). Limited Central Coherence can often result in difficulties such as social interaction, as well as non-social elements including insistence on sameness and routine, attention to detail rather than whole, obsession, preoccupations and existence of special skills. Frith (1989) proposed that individuals with ASD have weak central coherence. That is they

exhibit a failure to see the whole picture and show attention to detail as if each element is interesting in itself. It helps to see this as a 'cognitive style' rather than a deficit (Happe, 1994). There may be some advantages to weak central coherence, such as attention to detail (e.g. jigsaw puzzles) and musicality (e.g. repeating a tune).

The Executive Function Theory covers a multitude of higher cognitive functions e.g. working memory, impulse control, and cognitive flexibility (Happe and Firth 1996). People use the cognitive functions associated with the executive function theory when performing such activities as planning, changing task and paying attention to or remembering details.

People with Executive Function problems may have difficulty with planning, organisation, managing time and coping with unpredictability. These are all very important academic, social and emotional development skills: attention and flexibility are very important qualities for school success according to Jordan (1999) and (2002).

As yet there is no one theory to explain causes of ASD that can account for all its characteristic behaviours. None of the theories discussed in this paper apply to all those with ASD, and none are exclusive to this group. However, some theories may have something to offer our understanding even if not seen as a fully satisfactory explanation.

It has been stated that in the last 10-20 years there has been an increase in the number of children diagnosed with Autism (Ali and Frederickson, 2006). Professionals within health and education have debated about the possible causes for this which includes greater awareness about the symptoms amongst professionals, the broadening definitions or increase in children who have difficulties which link into the diagnostic criteria for ASD (Wing and Potter, 2002).

With a greater number of children being diagnosed with Autism comes an increased pressure for schools to provide appropriate support and resources to meet the needs of these children. This in turn impacts on the role of professionals linked to schools, such as Educational Psychologists (EP's). Therefore, EPs need to know how best to support schools in providing appropriate interventions which are tried tested and evidence based (Greenway, 2002).

As stated by Ali and Fredrickson, (2006), some Educational Psychology services (EPS) across the country have highlighted the effectiveness of social stories as an intervention, particularly in relation to advising schools about different types of interventions that can be implemented

for children who have ASD and as a part of this difficulty suffer other difficulties such as interacting socially with their peers and for teachers managing difficult behaviour linked to the ASD. The National Autistic Society publication by Hannah (2001) reported that if social stories are constructed properly they can work positively with children who are having difficulties understanding social situations and managing changes in routine (Hannah, 2001 p.83).

The Department for Children, Schools and Families, DCSF (formerly known as the Department for Education and Skills, (DfES) set up a working group in 2002 to support schools in managing issues relating to ASD. The document produced also included the use of social stories in a list of educational interventions. Other researchers such as Howlin (2005) and Mesibov (2004) have highlighted and referred to them as useful interventions. However, in recent years and despite gaining popularity within the literature, some authors such as Fox (2003) and Fredrickson (2002) state that there is limited systematic evidence on the effectiveness of the social stories approach.

This paper, therefore, aims to review the literature which argues the effectiveness of social stories to gain a better understanding of some of the evaluated research and therefore provide schools with a better understanding from an evidence based approach on how best to support children when implementing interventions.

Interventions to support children with ASD

Along with social stories many different interventions have been documented in the literature for supporting the development of social communication and interaction of children with ASD. These include educational interventions as well as parent training programmes. The DfES (2002) Autism Good Practice guide stated a number of educational interventions some of which are listed below.

- Applied behavioural analysis (ABA)
- Child's Talk
- Circle of friends
- Daily Life Therapy

- Early Bird programme
- Music therapy
- Picture Exchange Communication System (PECS)
- Portage programme (modified)
- Speech and language therapy
- Social stories

A review of research on educational interventions for children with Autism conducted by Jordan and Jones (1999) reported that although different interventions can be better suited for specific age groups there is no real evidence to suggest that any one intervention is better than another. There appears to be a consensus of findings that suggest early intensive education that involves parents and includes direct teaching of essential skills, with an opportunity for planned integration can produce significant positive changes.

Rogers (2000) also conducted a review of interventions and argued that children with autism, while demonstrating primary deficits in social interactions, responded to a wide variety of interventions aimed at increasing their social engagement with both adults and peers. Furthermore, several of the studies she reviewed demonstrated that such engagement directly affects other behaviours even when these behaviours are not specifically targeted by the teaching program. For children with speech and language difficulties, both the frequency of language used and the use of novel language constructions have been demonstrated to increase along with improvements in their overall social engagement. Additionally, inappropriate behaviour has been found to decrease during periods of active social engagement. Thus, social engagement appears to be a pivotal response, and a skill that leads directly to increased attainment of other important skills without the need for direct programming.

As suggested by authors such as Ali and Fredrickson (2006), one intervention in which children's social engagement can be promoted is through the use of social stories. Other approaches highlighted include Circle of Friends and social skills packages.

As identified in the case study (section one), social stories were discussed as an intervention to support EH's social engagement. As a TEP, the author felt further investigation into how best this intervention can be implemented was important to explore. Therefore, the next section discusses the social stories intervention in more detail and the how effective this approach can be to promote the social engagement of children who have difficulties related to the triad of impairments discussed in the previous section.

The evidence base for Social Stories interventions

Social stories were developed by Carol Gray to address the difficulties children with ASD have in understanding and interpreting social situations (Gray, 1994). The overall aim of the intervention is to provide appropriate social responses to complex situations, therefore promoting social understanding through individualised short stories. This is evident in Ozdemir's (2008) definition of social stories which states:

"Social stories are short individualised stories to support pupils in new and sometimes confusing social experiences (p.689).

Quirmbach, Lincoln, Feinberg-Gizzo, Ingersoll and Andrew, (2009), have reported that social stories support children with ASD to develop their thinking skills regarding social situations by allowing discussions about incidents that take place and why or who was involved along with discussing alternative responses to the situation. Gray (2000) states that this enables children to explore alternative responses and to understand their own feelings.

Originally social stories were developed in a written format and later changed to pictures to make them accessible to children of varying literacy skills (Tarnai and Wolfe 2008), the Gray Centre in 2000 incorporated visual images alongside the written social stories. This promoted the use of visual materials in supporting children with ASD. Gray and White (2002) found that children with ASD responded positively to sensory materials used in class.

Social stories can be written by teachers, teaching assistants or parents by applying the main principles which include the four basic sentences described in table 1 below.

Table 1: social stories instructions

Type of Sentence	**Description of Sentence**
Descriptive	Relate to the most important aspect of the story and guide the telling
Directive	Detail behavioural choices
Perspective	Refer to reactions, feelings and opinions of other people in the story
Affirmative	Express and shared beliefs of a given culture (school, family, community).

Adapted from Gray (2000, pg 4) and Ali and Fredrickson (2006, pg 358)

In addition to the four social stories descriptors noted above, Gray (2000) added two other sentence types which include:

- Control sentences: These provide the individual with understanding through the use of analogies.
- Co-operative sentences: These provide identifying information of who will provide help and how this will be provided to the individual.

(The Gray Centre 2009)

Although the general view by Gray (2000) regarding social stories is that they are written to cater for the individual needs of the pupil, there is a range of resources for teachers and parents that include books consisting of ready-made social stories and digital video disks of appropriate behaviour which children with ASD can model. However, this is criticised as it goes against the notion that social stories are unique to individuals and incorporates individuals' specific interests (Ali and Fredrickson, 2006). In response the Gray Centre (2009)

has stated on its website that these social stories are to be only used as an exemplar rather than a template.

Research on the effectiveness of social stories interventions

The review conducted focuses on articles published between 2000-2009. In total 18 articles were retrieved from a range of resources which included Psychinfo, Swetswise and Psycharticles. All articles obtained investigated social stories interventions when supporting children who have ASD. The author was able to locate additional articles and dissertation papers, however felt that it was important to review the published and reviewed research. The articles were compared for whether they focused on primary or secondary age pupils, whether they conducted case studies or multiple baselines, what behaviours the authors were targeting in the study and whether other interventions were being used alongside the social stories interventions and finally whether the article reported a positive effect on the targeted behaviours.

Table 2 below summarises the available research, the methodology used and outcome of the study:

Table 2

Author	School Age	Design	Target behaviour	Other Interventions	Outcome
Kouch and Mirenda (2003)	Early years and primary age	Case study	Aggression, tantrums, eating problems and sexualised behaviours	Pictures and verbal prompting	positive
Delano and Snell (2006)	Primary age	Multiple case study	Attention seeking and initiating interactions	Token Economy and Peer training	Positive and negative
Hutchins and Prelock (2006)	Primary	Case Study	Listening skills and turn taking	Comic strip conversations	positive

Author	School Age	Design	Target behaviour	Other Interventions	Outcome
Toplis and Hadwin (2006)	Primary age	Case study	Routines and learning behavioural consequences	Pictures and photographs	Positive and negative
Bernard-Ripoll (2007)	Primary age	Case study	Recognising and understanding emotions	Photographs and videotapes	positive
Crozier and Tincani (2007)	Early years and Primary age	Case study	Appropriate play and interaction skills	Verbal prompts	positive
Dodd, Stephen, Hupp, Jewell and Krohn (2007)	Primary and secondary	Multiple Case study	Appropriate play skills	Photographs	positive
Reynourt and Carter (2007)	Primary	Single Case Study	Decreasing tapping	Verbal prompts	Positive
Schenk-Konberg (2007)	Secondary	Single Case Study	Appropriate behaviours	Pictures and photographs	Positive
Okada, Ohtake and Yanagihara	Primary age	Single Case Study	Reducing disruptive behaviour	Picture symbols and photographs	Positive and negative
Ozdemir (2008)	Primary age	Multiple Case study design	Disruptive behaviour	Stick figures	positive
Scattone (2008)	Primary age	Multiple Case study	Increasing eye contact and non-verbal communication	Video tape and adult modelling	Positive
Quirmbach, Lincoln, Feinberg, Ingersoll and Andrew (2009)	Primary age	Multiple Case study design	Play skills and decreasing disruptive behaviour	Visual and verbal prompts	Positive

(Ali and Fredrickson 2006 pg 361)

The above table illustrates the social story intervention as overall a positive approach to targeting specific behaviours related to ASD. Most of the studies mentioned in the table have

been conducted using participants who are aged between 3-11 years old and further analysis of the research highlights a number of emerging themes which will be discussed in more detail in order to assess the effectiveness of social stories.

The majority of the studies discussed in table 3 have employed single or multiple case designs. Researchers such as Cohen and Manion (2007) have suggested that single-case designs are uniquely able to provide an experimental technique for evaluating interventions. This adds support to the rationale for why many of the studies use this design when collecting the data. Others have commented that single-case designs are time and cost effective, provide opportunity for more longitudinal evaluations, and are directed towards a particular subject or group (Reynout and Carter 2006 and Cohen and Manion 2007).

Ali and Fredrickson (2006) added that this approach is often commended by practitioners as it integrates research and practice. However, there a number of problems with the use of single-case design which include the ambiguities introduced by trends and variations in baseline data and with the generality of single caser research (Cohen and Manion 2007).

Through further analysis of the studies there was demonstrated to be three types of single case designs employed: descriptive case design, single case experiments, and case study with reversal design (Ali and Fredrickson, 2006). Some of the studies such as Bernad-Ripoll (2007) and Scattone (2008) have employed a repeated measures approach at each phase of the study, this could be argued as a more rigorous method of data collection and therefore offer high levels of validity (Quirmbach et al 2009). However, this is still criticised by researchers such as Dodd et al (2007) on the grounds that it can increase the likelihood of confounding variables such as, practice effects, fatigue. This is highlighted as a disadvantage of single case design by Cohen and Manion (2007).

The descriptive case study focuses on narrative accounts of events. For example, the response to intervention or change over time. It is arguable that descriptive case study designs are considered as less rigorous than single experiment design due to reasons such as over reliance on the researcher's interpretation of the data analysis.

Finally a small number of studies such as Toplis and Hadwin (2006) have employed a study with reversal design. This means that the effect of the intervention on behaviour is measured by withdrawing and then re-initiating the intervention (Ali and Fredrickson, 2006). However, this has been criticised on ethical grounds as its withdrawing effect can cause distress to children who are sensitive to changes in routine.

Another popular experimental design used by studies evaluating the effectiveness of social stories is multiple-case designs (Delano and Snell 2006, Scattone 2008 and Quirmbach et al, 2009). Fredrickson (2000) described this design as "more sophisticated than those used by the studies that focused on a single participant (p.368). The advantages of this approach include that each participant serves as a control for other participants, which is in contrast to children with ASD, as all are on different levels of the spectrum. A limited number of studies employ this approach because it becomes difficult to ensure all participants are exposed to the same experimental conditions, in this case level of exposure to the social stories intervention. This would impact on the results of the studies because it would be difficult to eliminate a range of confounding variables e.g. the effects of other interventions which are being taught alongside social stories.

Another criticism of the multiple-case design studies includes the selection of participants and sample sizes. Quirmabch et al's (2009) study used the largest sample of children (45) diagnosed with Autism, with others using two or three. The samples were selected by school staff which would mean the sample reflected the staff members own definition of disruptive behaviour. In reference to participant selection it should also be noted that the children in the above studies were selected as they had good literacy skills. This would not be generalisable to all children with ASD as caution would be needed particularly for children with ASD for whom a language difficulty is an associating factor.

The studies in table 3 have all sought to measure the effectiveness of social stories intervention for behaviours which are deemed as inappropriate. Positive outcomes are associated with the level of appropriate behaviours achieved by individual participants over a period of time. However, as the nature of the diagnosis, children with Autism have difficulties in generalising their learning. The studies can be critiqued for not addressing this in their

work. The measure of effectiveness is restricted to particular settings and, therefore, not able to show whether the effects are demonstrated in other settings such as the home environment (Rust and Smith, 2006, p.127).

The studies can also be critiqued in other areas such as the behaviours measured. As there is no identified definition of inappropriate behaviour, the studies have relied on teacher definitions of inappropriate behaviour. Studies such as Okada et al, 2008 have demonstrated success through the reduction of inappropriate behaviours. However, this is not clearly defined in their paper and does not identify whether alternative appropriate behaviours are developed. Scattone, (2008) has commented that an inappropriate behaviour may be replaced with another. None of the studies in this paper report changes in both inappropriate and appropriate behaviours.

The studies can be further critiqued in respect of the frequency of exposure to social stories. For example, Ozdemir (2008) and Quirmbach et al, (2009) used the story once every three days in their study. However, other studies such as Toplis and Hadwin (2006) used the social stories daily and Chan and O'Reilly (2008) used the intervention weekly. Therefore, it is difficult to evidence whether frequency of exposure impacts on the effectiveness of the intervention. More research needs to be completed in this area.

Another area of criticism for studies which have investigated the evidence base of social stories includes the difficulties in generalisation and maintenance. Delano and Snell (2006) conducted their research in America and in their study, two participants out of a sample of three children were able to generalise their learnt appropriate behaviour to a classroom setting. These findings, although supported by a British study conducted by Crozier and Tincani (2006), were unique as both used visual and verbal maintenance probes which could have helped in embedding the skills into the classroom setting.

Although the majority of the studies reviewed in this paper reported positive findings it is unclear whether improvements have been due to the social stories intervention alone. In many of the studies concurrent interventions were being carried out. For example, visual timetables,

adult modelling of appropriate behaviours and speech and language programs (Bernard-Ripolli, 2007 and Ozdemir, 2008).

The review of literature has identified a number of implications for future research. Firstly the views of users of social stories are limited. The author was unable to obtain studies which explored the views of parents, teachers, and children about the social stories approach. Ozdemir (2008) commented on the observations of children's positive reactions on receiving social stories input but did not clearly document the voice of the child. In addition, the Gray Centre states that parents use the intervention at home, but once again no published research is available.

Secondly, the research has targeted children with a diagnosis of ASD. Few studies have used children with other difficulties which are often linked to ASD such as Attention Deficit Hyperactivity Disorder (ADHD) and Speech and Language difficulties and Downs Syndrome (Okada et al, 2008 and Bucholz, 2007) have been documented. Therefore, further research of social stories could be developed to populations other than ASD.

Further questions still remain which were not fully addressed in the literature. These include to what extent children who are exposed to social stories intervention have ownership over the social stories. Does the level of exposure impact on the effectiveness of the intervention and how effective are the social stories in promoting the generalisation of the skills into different context? One area which needs further exploration is the social stories intervention within the context of the home environment.

More recently further questions about social story interventions have been raised by studies such as O'Connor (2009) who conducted a case study of a pupil with ASD who had difficulties in understanding the social skill of turn taking. Her results highlighted that due to the nature of the difficulties, social stories can be time consuming and unrealistic, as some children find it difficult to generalise their learning. She adds that in her case study every new turn taking situation would have needed a new social story. Further to this, another person involved in the turn taking situation may have needed to be included thus creating another social story. Making the process long and possibly confusing for the child.

Williams and Wright (2004, p. 53) suggest that weak central coherence means that children with ASD have difficulty in 'getting the gist' and that this applies to the child's use of language as well as his/her understanding of pictures, stories, events and objects. The focus of attention can be around detail rather than an appreciation of the whole event. It is difficult to know if Social Stories as an intervention can be effective for the child with ASD when weak central coherence is present.

Therefore the use of social stories needs to be tailored to the individual child, with professionals being aware of the wider concerns relating to the associated difficulties the child may have, which will include difficulties associated with the triad of impairments. All of which would need detailed investigation in order to tailor the social stories intervention.

Implications of Educational Psychology Practice

As a TEP this information is very useful when consulting with schools about appropriate interventions for children with difficulties associated with ASD. As suggested by Williams and Wright (2004) knowledge of the child's overall need will impact on how social stories are used. Therefore the overall effectiveness of the intervention for the individual child will be affected. With the time constraints often associated with such interventions other simple interventions which do not require a high level of Teaching Assistant time could be favoured by the SENCo if the appropriate intervention is not tailored to the needs of the child.

The research discussed above indicates that the use of social stories can be beneficial for children who have ASD and that the approach can be supported either alone or in combination with other approaches, provided that the social story is unique to the individual and monitored over time with the child's targeted behaviours. This approach has been used in schools therefore can be employed with caution. The role of the EP could include exploring the appropriateness of the intervention based on the overall needs of the child. Overall it appears that there are a number of interventions promoting social engagement for children who have ASD, and the role of the EP could be seen as supporting schools in identifying the most appropriate interventions for the individual child through problem solving, monitoring and reviewing interventions in place.

In the case of EH social stories could be implemented using then knowledge and understanding of the TEP. Particularly when discussing transition to secondary school, EH could be supported to write a number of social stories for the many social situations that he could be presented with on a day to day basis.

Conclusion

Overall, the studies discussed in this paper have measured aspects of effectiveness with regards to social stories. This may provide professionals such as EPs with the confidence to encourage schools to employ the social stories intervention with caution. The empirical research highlighted that there are many variables and each piece of research focuses on different aspects of social stories. In addition, the research available has generally reported positive outcomes in relation to targeted behaviours for a variety of age groups (preschool to primary school) and across settings. Behaviours targeted were as diverse as 'self help skills' to 'inappropriate sexual behaviours' (Tarnai and Wolfe 2008).

However, it is important to note that the majority of the studies used single case design methodology, as well as incorporating other interventions alongside the social stories intervention. Therefore, the findings of the single case designs cannot be generalised in all settings. It could be argued with the increase in the number of single case designs in this area, the validity and reliability of this method could increase and warrant social stories intervention as an effective and evidence based intervention.

Furthermore, there is a small body of research which highlights the importance of ensuring the social stories intervention is tailored to the individual needs of the child. Due to the nature of the difficulties associated with ASD sometimes children may find it difficult to generalise the social stories to other contexts, particularly if they become more complex i.e. more then one person in the story. This highlights the complex nature of the behaviours social stories are hoping to target. This in turn has meant the evidence base is largely single case study research and becomes less clear about whether social stories are effective at the stage of generalisation and are often supported by other interventions such as direct modelling of social skills.

The author suggests further research is required to determine exactly which of the social stories' factors contribute to change in targeted behaviours in children with or without ASD. In addition, further examination of the maintenance of these skills would be imperative, particularly for a clinical and non-clinical participant groups.

In conclusion, the popularity of the social stories approach has continued to grow in schools. The approach has made a big impact on schools without, more recently questions arising about its rather limited empirical evidence and knowledge of long term effectiveness.

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APPENDICES

Appendix 1

PBR Preparation and Record Sheet

Please complete all boxes (use n/a if appropriate)
To be completed electronically and sent to: [redacted]

Date of Referral:
School Referring:
Name and Role of Referrer:
School Contact Telephone No: [redacted]

For office use only:
PBR Date:

Actions:

Will a member of staff be attending the PBR meeting?	Yes *(delete as appropriate)*	Person attending: Mrs. S. [redacted]

Section 1	**Nature of Referral**				
Whole School Issue		Group Issue		Individual Pupil *	X

Section 2 To fill in for Individual Pupil Referral *(For Whole School and Group Issues go to Section 3)*

Confirmation that Parent/Carers and Child/Young Person's views have been obtained: *

IMPORTANT: Individual pupil's cannot be discussed at the PBR unless Section 7 of this form has been completed and is available at the PBR meeting.

Child/Young Person's full name	DOB	UPN	Gender	NC Year
	[redacted]	[redacted]	Male	Yr.

Parent(s)/Carer's name/s	Home/family address	Contact telephone numbers
[redacted]	[redacted]	

First language of child/young person: English Interpreter Needed No	First language of parent/carer: English Interpreter Needed? No	Religion: Looked after child? No

Ethnicity

White:		Asian or Asian British:		Chinese or other Ethnic:	
British	X	Indian		Chinese	
Irish		Pakistani		Vietnamese	
Other		Bangladeshi		Other Ethnic group*	
Mixed:		Other Asian background *		Decline to provide	
White & Black Caribbean		Black or Black British:		* **Please specify below**	
White & Black African		Caribbean			
Other mixed background*		African			
		Other Black background*			

School Action ( ) Action Plus (x) Statutory Action ( ) Statement ( )

Updated September 2008

Other Agencies Involved (Please include Key Names, Role and Contact Details)

Social Services

Looked After Child ( ) Child Protection ( ) Child in Need ( ) Other:

Education e.g. Educational Psychologist, Specialist Teaching Service
3.11.1004 - [redacted] Specialist Teaching Service, Dyslexia Screening,
13.12.2004 - [redacted] Specialist Teaching Service, Irlen Screening.

Health e.g. CAMHS, Speech and Language, School Nurse
27.6.2002 - [redacted],Speech and Language Therapist
25.4.2005 - [redacted], Staff Grade Community Paediatrician,
20.6.2005 - [redacted], Staff Grade Community Paediatrician,
17.8.2006 - [redacted], Staff Grade Community Paediatrician,
20.11.2006 - [redacted], Speech and Language Therapist.

Other: e.g. Educational Welfare, MABSS, Counsellor, YOS
Undated – [redacted] M.A., Adv.DipSEN, F.E.A.I.D., Director Irlen Centre, [redacted]. (Infant School)

Section 3 **To be filled in for Individual Pupil, Whole School and Group Referral**

Nature of

~ [redacted] has difficulty understanding social cues and dealing with strong emotions.
~ He has trouble maintaining friendships – he can often misread situations.
~ When talking about science and his hobbies he is very articulate; however he lacks the appropriate language in other areas of the curriculum.
~ [redacted] also has very poor literacy skills which is mainly linked to the dyslexia and Irlens. He only uses overlays when prompted.
~ He is unable to work unaided or independently.
~ He finds it difficult to take responsibility for his actions.

Describe the present situation

At the moment [redacted] is working at a very low level 2c in literacy. This does not appear to have been improved despite having daily reading for over a year. He is less prone to violent outbursts but he struggles to deal with conflict. Although his maths is better than his literacy (3b) he still relies on visual aids. He can do basic calculations but doesn't understand the concept behind it. He has made little or no progress. He is very isolated in class from his peers; through his own actions and his understanding of situations.

Strengths

Science
Helpful to adults in the classroom
Steam engine
Telling jokes.

National Curriculum Levels and other relevant assessment details

	Yr. 2	Yr. 3	Yr. 4	Yr. 5
Maths	2c	2b	2a	3b (Yr. 4 paper)
Reading	1c	1b	2b	2c (Yr. 4 paper)
Writing	1c	1b	2c	<2c (Yr. 4 paper)

Yr. 5 ~ NVR 104 - VR ~ 75

What factors may be contributing to this situation?

Dyslexia screening assessed by Specialist Teaching Service, - result is 'considerably at risk'. (3.11.04).

Irlen Screening 13.12.2004 – overlays chosen – Grey over 2x rose.

Medical assessment – Dr [redacted] 25.4.2005 – diagnosed specific learning difficulties, behavioural difficulties, namely hyperactivity, fidgetiness, lacks concentration. He is distractible at school and he can be impulsive – fulfils the diagnostic criteria for attention deficit hyperactivity disorder. He also showed oppositional defiance in that he does not admit to what he has done.

Medical update – 20.6.2005 – problems highlighted :-

~ Attention Deficit Hyperactivity Syndrome
~ Learning Difficulties (on School Action Plus)
~ Problems with social interaction and peer relationships.

Medical assessment – 17.8.2006 (Junior School) – Dr [redacted]
Summary – fulfils the criteria for Autistic Spectrum and he is mainly having difficulties with social interaction, speech, language and communication problems associated with some learning difficulties.

What strategies have already been tried and what were the outcomes?

Yr. 3 - 1:1 literacy,Springboard, Nurture group, ALS, Social skills group
Yr. 4 - Springboard, Nurture group, Social skills group, ALS, daily reading.
Yr. 5 - Speech and language, Nurture, Maths catch up, Springboard, daily reading, ALS, Nurture group Thinking project, small group writing.
Yr. 6 - Some support in class, phonic work, 1:1 reading, Springboard, Nurture group, small maths group small group writing.

What do you hope to get from this PBR consultation?

Advice about:

- How we can best help , to fulfil his potential.
- How we can help , to improve his basic literacy skills.
- How we can help to relate more easily to other people so that he manages the transition to secondary school successfully and makes the most of KS3 and KS4.

Section 4 To be filled in for Individual Pupil Referral
Parental/Carers Views of the situation [redacted]'s parents want him to achieve his full potential. They want him to improve his reading, writing and social skills.
Pupil/Young Person's View of the situation I would like to be able to understand more words and be better at writing faster. I would like to be better at making friends as I haven't got any friends at the moment.
Date of last meeting with Parents/Carers and agreed outcomes 22.10.2008 ~ Agreed outcome for school to go to PBR and for school to help parents with transition procedures.

Section 5 To be completed at PBR	
PBR Discussion Notes (Main points) ❖ Possibly has ADHD – not confirmed ❖ Very de-motivated ❖ With very skilled teacher, strategies all put in place & awards system in place ❖ Very reliant on adults ❖ Does some work in Lego group ❖ Only boy in a family with 3 sisters ❖ Non-compliant at home ❖ Doesn't always engage ❖ Older twin sisters go to ❖ Doesn't want to engage in any conversation re transition ❖ Visited Wilmington Enterprise College ❖ Mum is quite rigid and might need some help with situation at home ❖ [redacted] would like to be able to write faster and make friends – school have tried everything ❖ Fine and gross motor skills issues	
Actions agreed at the PBR ➢ School to check with Mum whether he has been back to Dr [redacted] for ADHD diagnosis ➢ Autism outreach support can be accessed through PBR through [redacted] but only if he has a diagnosis ➢ [redacted] to be involved and will contact [redacted] ➢ School to arrange a meeting between [redacted] and school	Lead Professional Name [redacted] Phone Number Start date:

Section 6 Type of support provided. To be completed at PBR.

Whole School Issues ☐ Group Issue ☐ Individual Pupil ☐

Communication & Interaction (C&I) ☐

Cognition & Learning (C& L) ☐

Behavioural, Emotional and Social (BESD) ☐

Social Care (MABSS) ☐

Physical & Sensory ☐

Other:

Section 7 Parents/Carers and Child/Young Person Views and Consent

- *Part 1 should be completed by the referrer.*
- *Part 2 - the referrer should ensure that the views of the parent/carer are recorded **(but see footnote)***
- *Part 3 - where it is appropriate to secure the views of the child or young person, these should be recorded here. Where possible, the parent/carer and child/young person should record their own views, otherwise the referrer or other professional can scribe for them **(but see footnote)***
- *Part 4 seeks the consent via signature of the parent/carer and child/young person to the sharing among agencies of relevant information held by each agency.*
- *Part 5 should be completed by the referrer.*

PART 1Basic details

Child/Young Person's full name:	
Date of Birth:	
Parent/Carer full Name:	

PART 2 Parent/Carer Views – *see footnote*

What would you like to happen and who do you think could help with this?

We would like to be able to achieve his full potential. He needs to improve his reading and writing and social skills.

We feel needs specialist support as he does not learn as other children do.

PART 3Child/Young Person Views– *see footnote*

What would you like to happen and who do you think could help with this?

I would like to understand more words and be better at writing faster. I would like to be better at making friends as I haven't got any friends at the moment.

Footnote: *Where the referral is made for a very young child, or at the time of diagnosis, it may be considered inappropriate to seek child or parental views, and these will be recorded later by the initial key worker (eg, Portage, HI, Pre School, VI worker, etc)*

PART 4 Parent/carer and child/young person consent to information sharing

Sometimes when you and your family have a problem you may need to speak with a lot of different people such as teachers, doctors, speech therapists, social workers etc. to get help. In order to help/ enable these professionals to work together to help you or your family, they often need to share information that each of them holds. This helps them to better understand your needs and organise their services to meet them.

We would like, therefore, to have your consent to the agencies (usually Education, Children's Social Services and Health) sharing the information held by them that may prove useful in helping to plan for

meeting your or your family's needs.

Obviously any personal information about you and your family will be discussed under strict rules, in line with the law, and will not be given to any other persons who are not involved in the process of planning to meet your and your family's needs.

The Data Protection Act says that the processing of information should be fair and lawful, that it should be for a clear and specified purpose, that only relevant information should be disclosed, that it should be accurate, that it should be shared and held only for as long as necessary, that the rights of the data subject must be upheld, and that the system should be secure. The law also says we must share information in order to safeguard or protect a child or young person.

I agree to information being shared and discussed between professionals to help me/my child. I understand that I will be consulted following these discussions regarding any future planning and actions.

Name of child/young person: .....

Signature: ..... Date: .....

Name of principal/main carer: .....

Signature: ..... Date: .....

PART 5Referrer Details

Name: ..... Title: .....

Service/Agency: .....

Signature: ..... Date: .....

If, exceptionally, consent has not been sought, or if the parent/carer and/or child/young person has not given consent, please say why below;

[Appendix 2]

— Initial meeting 3/06/09
—Mrs Ondhed, Mum + SENCO

Monday 22nd June anytime after 11.30am

YR6 : ~~Asperger~~ ADHD . ASD. — social interaction
problems in cognition. — speech + language
— learning difficulties
— reading + writing

Maria worked with mum - so less anxious,
and managing his behaviour

- full-cognitive
- More-Strategy for how he learns.

LEIGH Academy.

further cognitive assessment -
- is he suitable for Spectrum Centre.
Screened for DSyk + Irlen + SP+L + Paediatrician

SPtLT Assessent '06 –
standard score. S.

Development Assessment.

Need to review SPtLT input.

✱ Mum's news – Concerns about transition requires ~~a~~ TA one to one.

✱ – Transition meeting for – 22nd June –
– Takie washington to do transition work.
– Anne to organise a TA.

– full cognitive assessment.

Issues
Transition.
processing is an issue
understanding + processing is an issue.

Need
– Clearity on his abilitys + areas of
– achieve his full potential.
– No key to how he learns.
– hates science
– Extra support for his reading
private tution.
– very limited progress.
– NV reasoning is not that far off.

In school

strategies – small group work -
for literacy, reading, writing
–
observation – - practical understanding
visual learning. ?
- feels a! cognitive – processi

– clear instructions + two - small steps.
what can do if learning is in
written form

Even if he gets all ASD strategies it
will not help his learning.

Level of Hypothesis	Source	Guiding Hypothesis	Method of data collection	Findings/Interpretation
Individual / Class	TEP	EH has "learned helplessness" in class with regard to writing.	Observation Appendix 4 Interview with Pupil (Appendix 5) Interview with parent (Appendix 6)	Observation (11/06/09) • EH was drawing a picture while others were completing a project. Observation 11/06/09 • EH waited for TA supported before he began to project Interview with Pupil 11/06/09 • EH stated that he preferred to use his computer to write things down Interview with Parent • EH avoids homework tasks and in order to complete the she writes EH's thoughts on to paper. **Due to the nature of his difficulties, EH often shows reluctance to engage in a task independently. This is evident at home also. As EH's mums supports him to complete homework tasks. Therefore the hypothesis is supported.**

Level of Hypothesis	Source	Guiding Hypothesis	Method of data collection	Findings/Interpretation
Individual	TEP Parent	EH has low self-esteem.	Observation (App 4) Parent Interview (app 6) The Self Image Profile (Burton, 1994, in Beaver, 1996) (App 7)	Observation 11/06/09 • EH was not involved in the whole class leaver's play. He said that he did not get asked to participate. • During the assessment EH repeated "I'm not very good at this" a number of times. Parent Interview • "Lack of confidence" is one of Mum's main concerns regarding EH. The Self Image Profile • EH described himself as not very confident, feeling very different from others, very nervous and very shy. • EH described himself as "not at all" good at spelling or writing or reading, but "very much so" good at science. **EH appears to show low –self esteem regarding learning and social interaction with peers therefore the hypothesis is supported**

Level of Hypothesis	Source	Guiding Hypothesis	Method of data collection	Findings/Interpretation
Individual	CT	EH's literacy difficulties impact's upon his ability to engage in reading and writing tasks.	CT interview (App 8) Observation (App 4) Assessments (App 7)	CT interview • EH is not good at spelling. • His NC levels for reading and writing are below average Observation 11/06/09 • While the whole class was conducting literacy task EH was colouring a differentiated task. Assessments: • Dyslexia screening: states he is at risk • Salford reading age is low. • British Ability scales II scores for Verbal Cluster were within the average range. **Although EH is identified as having literacy difficulties and may well have reading difficulties. His overall verbal ability is within the average range, suggesting that there may be some underlying phonological difficulties, which mean he struggles with reading tasks. Therefore the hypothesis is only partially supported and a phonological assessment may clarify this concern.**

Level of Hypothesis	Source	Guiding Hypothesis	Method of data collection	Findings/Interpretation
Individual	CT Parent	EH likes routine and gets upset when this is disrupted.	CT Interview (App 8) Parent interview (App 6)	CT interview • EH gets upset if the class routine is disrupted. Parent interview • Can't change EH's routine • EH cannot remember routine for coming home from school **With the difficulties associated to his ASD diagnosis and the information provided by others this hypothesis is supported.**

Level of Hypothesis	Source	Guiding Hypothesis	Method of data collection	Findings/Interpretation
Individual / Class	CT Parent Pupil	EH does not have many friends and does not respond well in social situations.	CT interview (App 8) Observation (App 4) Parent interview (App 6) Pupil interview (App 5)	CT interview • EH is accepted by the children in the class. • EH will join in group activities when required of him but generally keeps himself to himself. Observation 11/06/09 • Several children offered EH help and advice which he accepted. He didn't engage with them beyond that. • During the class play he remained on the periphery Parent Interview • EH plays well with other children if they're "thrown together" • EH doesn't know social conventions (e.g. saying hello/goodbye). • Will become angry if social situations do not go his way. • Pupil Discussion • EH named only one person who was his friend **From the information obtained it can be stated that EH finds social situations difficult to manage therefore the hypothesis is supported**

Level of Hypothesis	Source	Guiding Hypothesis	Method of data collection	Findings/Interpretation
Individual / class	TEP	EH does not know which materials are required for tasks.	Observation (App 4) Parent Interview (App 6)	Observation 11-06-09 • EH took around 5 minutes to find a reading book and needed to be asked directly by the CT to do so. Observation 11-06-09 • EH took a long time to get his spelling book when asked to by the teacher. Parent Interview • EH requires daily reminders about what he needs for school each day. **Both EH's mum and class teacher provide EH with daily reminders about materials and tasks he requires, without this support EH would find it hard to remember. Therefore the hypothesis is supported.**

Individual / class	CT Parent	EH responds well to incentives	CT interview (App 8) Parental Interview (App 6) Assessment (App 7)	CT interview • EH responds well to the computer being used as an incentive to complete work. Parental Interview • EH responds very well to the computer being used as an incentive. Assessment • EH responded well to praise and worked well when he was encouraged to do so. **This information highlights that EH does require targeted incentives to motivate him, this can include positive praise as well as rewards. Therefore the hypothesis was partially supported.**

Individual / class	CT TEP	EH is easily distracted and avoids tasks when he finds them difficult.	CT interview (App 8) Observation (App 4) Assessment (App 7)	CT interview • EH can't sit still for a long period of time and will wander round classroom Observation 11/06/09 • EH spent 5 minutes locating his reading book EH didn't spend a long time reading his book and got up and went to the tap before returning to his seat again. • However, EH concentrated well during his group maths lesson, listening and responding appropriately to questions Observation 11/06/09 • Sharpened pencil twice during 45 minute period. • Went to toilet twice during 45 minute period. Assessment 11/06/09 • EH did not wander off at any point while completing this task, during the discussion or while completing the assessments. **This information suggests that although in larger unstructured settings, he does respond well to structured activities, therefore the hypothesis is partially supported.**

interview (App 6)	• EH is a member of the Scouts and was a Cub. He is currently not attending Scouts because of the late finishing time. • EH is also part of a ASD group run by the Parents consortium **EH has a number of opportunities to socialise outside of school through a number of after school clubs therefore the hypothesis is rejected.**

Level of Hypothesis	Source	Guiding Hypothesis	Method of data collection	Findings/Interpretation
Community	TEP	EH has little opportunity to develop his social skills outside of school	Parental interview (App 6)	Parental Interview • EH is a member of the Scouts and was a Cub. He is currently not attending Scouts because of the late finishing time. • EH is also part of a ASD group run by the Parents consortium **EH has a number of opportunities to socialise outside of school through a number of after school clubs therefore the hypothesis is rejected.**

Appendix 4

11/06/09

Observation of

1pm

⇒ sitting in front of class.
⇒ whole class activity regarding project.
⇒ not completed this instead is colouring picture, related to the project.
⇒ took some time to get started after break/lunchtime.
⇒ spent some time looking around the room, looking for bag, sharpened his pencil + appeared to be off task.
⇒ was asked to give spelling book in.
⇒ was redirected by CA, was given prompts "Do you know what you've got to do" CA. Not sure if he understood CA instruction.
⇒ spent some time looking around
⇒ another pupil asked if he wants support "No" no eye-contact head down + no further interaction with anyone.

1.30pm

CA
⇒ Asking all children to line up for class assembly practice. - didn't respond! was asked again by teacher, got up + lined up.

1.45pm

⇒ leaves assembly - standing on the periphery no interaction with any peers, - asked to toilet again went earlier at 1pm.

Appendix 5

11/06/09

Individual session with

=> was happy to engage did appear shy - "no eye contact"

=> asked why he was being asked to see me I explained, showed some response to this.

=> Asked what he likes in school good at science + maths, enjoys these subjects.

=> Hate writing, I prefer to use the computer & "A" that why you didn't enjoy the project work earlier."
C - I prefer to draw or type on the computer.

=> friends with in class
+ other friends.

=> C engaged well in the assessment although concentration did wear off & to save time + asked for breaks. when someone walked by cameron got distracted

just as lunch break was over.

Meeting with Mrs [redacted] + SENCO (D/HT + C/TC).

discussed her concerns which include

⇒ Transition
⇒ literacy difficulties
⇒ friendships
⇒ lack of independence in class + homework tasks.

⇒ spends a lot of her evenings encouraging + supporting C- to complete ~~co~~ homework.
" I ~~write~~ write all his ideas for him + this helps him think of what he wants to write.

⇒ Concerned about his 'lacking in confid
he is anxious about secondary School.

⇒ C. needs support with getting himse ready for school daily.
can be independent sometimes

" Mum appears quiet anxious.

his behaviour has been difficult to manage + this impacts on her stress as she is always worrying about C-

⇒ doesn't like changes in routine.

⇒ Sometimes he becomes difficult to manage when he is with other children.

⇒ finds it hard to understand why he can't get his own way will often misunderstand comments made by other kids.

will play/interact when he's with other kids.

⇒ I remind him daily what he needs for school, but he still forgets I worry about the demands of secondary school. 'he will not cope'.

⇒ likes physical activities, enjoys things with scouts + parents consoles him. Loves his PC I use this to reward him for doing well.

Appendix 7

The Self Image Profile
For Children (SIP-C)

Richard J Butler

Name: Age:

Sex: (Male) / Female Date: 11/06/09

Please read the instructions carefully. If you do not understand, ask for help.

1. First, please shade the [ ] box according to *how you think you are* using the 0 - 6 scale where, 0 means 'not at all' like the description and 6 means 'very much' like the description.

2. Then, put a star in the [*] box according to *how you would like to be*.

There are no right or wrong answers. Use any number along the scale to show how you think of yourself.

DO NOT WRITE BELOW LINE

SI + ve	SUM OF ITEMS 1 - 12	32,
SI - ve	SUM OF ITEMS 14 - 25	40
SD	SCORE ON ITEM 13	5
SE	SUM OF DISCREPANCY SCORES	70

negative self

		Not At All						Very Much	DISCREP SCORES
		0	1	2	3	4	5	6	
1	Kind								1
2	Happy								3
3	Friendly								2
4	Funny								2
5	Helpful								2
6	Hard Working								3
7	Lively								3
8	Honest								2
9	Like Sport								3
10	Brainy								3
11	Sensitive								3
12	Like the Way I Look								4
13	Feel Different from Others								5
14	Lazy								3
15	Get Picked On								2
16	Moody								3
17	Mess About in Class								2
18	Shy								5
19	Always in Trouble								3
20	Cheeky								3
21	Teases Others								0
22	Easily Upset								3
23	Bossy								1
24	Bad Tempered								3
25	Get Bored Easily								6

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C D E
6 7 8 9

School Age Summary

Name:

Male / Female

	Year	Month	Day
Date Tested	04	06	17
Birth Date	98	01	04
Age	11	04	

(Disregard the days)

CORE SCALES	Ability Score	T-score	% ile	Difference from Mean Core T-score	Significance? p=0.05	✓/X	Frequency (%)	Age Equivalent
Recall of Designs	84	43	24		12			
Word Definitions	134	60	84		10			
Pattern Construct. ☐ Std. ☐ Alt.	115	38	12		9			
Matrices	89	41	18		10			
Verbal Similarities	76	33	4		9			
Quantitative Reasoning	94	42	21		9			
Mean T-Score		Total T-score						
DIAGNOSTIC SCALES								
Recall of Objects – Imm. Verb.					14			
Recall of Objects – Imm. Spat.*								
Recall of Objects – Del. Verb.*								
Recall of Objects – Del. Spat.*								
Speed of Info. Process.					9			
Recall of Digits Forward					12			
Recognition of Pictures					15			
Recall of Digits Backward					10			

ACHIEVEMENT SCALES	Standard Score	Difference from GCA	Significance? p=0.05	✓/X	Age Equivalent
Number Skills			11		
Spelling			11		
Word Reading			9		

*Converts directly from Raw score to T-score/Percentile

CLUSTERS	Verbal	Non-verbal Reasoning	Spatial	GCA
	60	41	24	
	33	42	38	
Sum of T-scores	93	83	62	238
Standard Score				
Confidence Interval (☐ 90% ☐ 95%)	–	–	–	–
Percentile				

Special Non-verbal Composite

*

Verbal ability 94 34th centile.

non-v 86 18th centile

spatial 66 1st centile.

GCA = 79 8th centile

Mean T score = 40

Comparisons with the GCA

	Observed Difference	Significance? p=0.05	✓/X	Frequency (%)
Verbal		9		
Non-verbal Reasoning		9		
Spatial		10		

Between Cluster Comparisons

	Observed Difference	Significance? p=0.05	✓/X	Frequency (%)
Verbal v Non-verbal Reasoning		14		
Verbal v Spatial		16		
Non-verbal Reasoning v Spatial		16		

Within Cluster Comparisons

	Observed Difference	Significance? p=0.05	✓/X	Frequency (%)
Word Definitions v Verbal Similarities		10		
Matrices v Quantitative Reasoning		10		
Recall of Designs v Pattern Construction		11		

Observed v Predicted Achievement Comparisons

	Observed Score	Predicted Score	Difference (O–P)	Significance? p=0.05	✓/X	Frequency (%)
Number Skills				10		
Spelling				9		
Word Reading				8		

NOTES

Appendix 8

11/06/09.

Consultation with C/T + SENCo.

⇒ Works better with short, sharp repeated instructions

⇒ he is easily distracted + needs to be supported by or TA for most tasks.

⇒ Verbally very capable but struggles with non-verbal skills, reasoning + comphrehension.

Strengths
science
factual based information

NC levels

M – 3a
S – 4a
R – 1c
W – 1/2a } literacy is key area of difficulty.

no score for spelling (NA).

avoids reading tasks.
won't co-operate with reading tasks
is aware of his weakness +
computer time is used as an incentive

If he has to, doesn't usually understand can get into fights at play I think its because he doesn't get the rules of the game.

=> does get distracted easily likes to wander around classroom

=> social skills is a concern
— no clear bond with peers plays with year 3.
=> needs some intervention to support social skills
seems better with visual prompts.
=> does go to clubs, but still has not made any clear friendships

Appendix 9

Confidential to parents and those professionally involved with the child/young person.

Date of Consultation: 22.06.09 06.07.09

Consultation No: 1

Kent Educational Psychology Service

Strictly Confidential

Consultation Record

* **Please delete as appropriate**

Child's Personal Details

Name:

Address:

Postcode:

Date of birth: **Chronological Age:**

Gender: **Sexuality (Optional):**

School:

UPN: **National Curriculum Year:** Year 6

Religion: **Home Language:** English

CAF: **Lead Professional (if known):**

Person(s) with Parental Responsibility

Name(s):
Relation:

Address:

Postcode:

Home Telephone: **Day Telephone:**

Present at consultation meeting:	
Name:	**Designation:** School SEN-co Trainee Educational Psychologist (TEP) Parent Year 6 Class Teacher Pupil Family Action [redacted] (ASD Outreach)

Issues

was referred to the Partnership Based Review (PBR) in April due to the school and parental concerns regarding difficulties with social communication and his general learning difficulties.

has been seen on a number of occasions by Dr .J. [redacted] (Community Paediatrician), most recently on the 17.08.2006 and has been highlighted as having specific learning difficulties, social interaction difficulties, speech, language and communication problems associated with some learning difficulties and some behavioural issues, namely hyperactivity, fidgetiness, lacking in concentration and distractibility. has been given a diagnosis of an Autism Spectrum Disorder (ASD).

has received support from Specialist Teacher for Cognition and Learning. He was also screened for Dyslexia and this highlighted that is 'considerably at risk'. He has also been screened for Irlen's syndrome and has been provided with overlays.

The school referral states that has difficulties in understanding social cues, dealing with strong emotions and maintaining friendships. He is highlighted as having poor literacy skills. struggles to work unaided or independently and will only use his overlays when prompted by the teacher.

is currently working at a low 1C in literacy. The school states that this does not appear to have improved despite having daily support with reading. enjoys science and can be very articulate about this topic or other hobbies. National Curriculum score for maths is at a 3b but the class teacher states that although can complete basic mathematical calculations he struggles to grasp the reasoning and problem solving aspects of mathematics, he also relies heavily on visual aids when completing maths tasks.

Assessment and/or intervention information

Meeting with SENCo and Class Teacher

Ms (Teacher Yr 6) reported that often struggles to remain motivated during learning tasks, and can be easily distracted by his environment. She added that has received one-to-one support by both a TA and herself in most learning tasks. In order to support learning, she has simplified all learning tasks and communicated through short, concise, repeated instructions. However, she reported that still struggles with reading and writing tasks. She added that can verbally express his thinking. However, his non-verbal reasoning and problem solving skills are below-average in comparison with his peers.

current National Curriculum levels are Maths level 3, Science level 4, Reading level 1 and Writing level 1/2. Ms. has advised that attempts to avoid reading tasks. With tangible rewards, is able to read for ten-minute periods. She believes that is aware of his reading difficulties and therefore will not engage readily with reading tasks. His strengths lie in Science and History as he enjoys factual-based learning.

Both (SENCo) and (Teacher Yr 6) have stated that 's behaviour at school has improved. However, he still has difficulties in social interaction. Over the years (3-6) has been involved in numerous school-based social skills groups and attends a nurture group. However, still finds it difficult to build positive relationships with his peers.

Ms. stated that often plays with children younger than himself (from year 3), and that she has not observed a "clear bond" between and any member of his classmates. has formed a positive relationship with and she is concerned that he may struggle to manage within the secondary school environment unless he has developed a positive relationship with a key adult at his next school.

Meeting with

stated that she is concerned about s transition to secondary school. She feels that he has made very little academic progress this year and stated that his ability to process information is a concern to her. She added that she has introduced various strategies at home to support his literacy skills, including private tuition to develop 's reading skills. However, this has not had any significant impact on 's reading skills, as he still finds it difficult to make sense of information once he has read it. She stated that she would like to reach his full potential. She hopes that a transition meeting will help to manage his anxieties around starting secondary school in September.

One to One meeting with

During the (45 minute) observation conducted by the TEP, appeared to follow the class teacher's instructions, which included the completion of a history lesson worksheet.

from the class teacher to continue with his worksheet.

During the administration of the British Ability Scales (BAS II) appeared to be easily distracted by his environment, and required lots of encouragement to continue with the assessment. With encouragement and short breaks continued with the assessment and completed all six of the core sub-tests.

Table 1:

Subtest	T-Score	Percentile Score
Recall of design: Short term recall of visuo-spatial relationships through reproduction of abstract figures	43	24
Word definitions: Expressive Language, explanation of word meanings.	60	84
Pattern construction: Non-verbal reasoning and spatial visualization in reproducing designs with coloured blocks	38	12
Matrices: Inductive reasoning: identification and application of rules governing relationships among abstract figures.	41	18
Verbal similarities: Verbal reasoning and verbal knowledge	33	4
Quantitative reasoning: Inductive reasoning; detection and application of rules concerning sequential patterns.	42	21

Table 2: Cluster scores

Cluster	T-Score	Percentile Score
Verbal ability (includes Word definitions and Verbal Similarities	94	34
Non Verbal Ability (includes Quantitative reasoning and Matrices).	86	10
Spatial Ability (includes Pattern Construction and Recall of Design)	66	1

Percentile scores that fall between the 16th – 84th percentiles are considered to be within the broad average range for a child of 's chronological age.

scored within the broad average range for five of the six subtests. In particular, for Word Definitions he scored in the high end of the average range when compared to children of his chronological age. This suggests a relative strength in this area. He scored within the below average range for Pattern Constructions and Verbal Similarities, both tests require reasoning skills, his score for Verbal similarities was significantly low therefore suggesting this as an area of difficulty for .

Current thinking

's overall verbal skills lie very much within the average range when compared to children within his age group. However there was a significant difference between the two verbal ability subtests. He has strengths in Science and enjoys factual-based information. has received one-to-one support and a differentiated curriculum. However, he still finds reading tasks challenging. This could be due to his difficulties in processing instructions provided to him orally, and difficulties in applying reasoning skills to set tasks.

's difficulties in understanding verbal instructions have meant he often misinterprets social cues and therefore finds social interactions with his peers difficult.

Strategies and actions agreed

- Break curriculum tasks down into manageable parts and provide explicit step-by-step directions. This is especially important when new information in being introduced as well as when reading comprehension and math tasks are presented. may benefit from being provided with additional cards with instructions on them to use along side instructions written on the white board. He may also benefit from a visual timetable.

- Precision Teaching technique may help to recall letters, words and numbers. This is a daily tool consisting of high repetition, recall and self monitoring. The technique involves the teacher / teaching assistant identifying all high frequency vocabulary and numeracy concepts that is not familiar with and working with him to identify these words in a multi-sensory way. The activities are should be motivating and the rate of progress is measured against the pupil over time, rather than against peers. This technique has a very good success rate and may help raise him levels of self esteem and motivation to learn.

- Ask to repeat instructions given to him orally and provided visually, this will help to reinforce concepts presented, provide structure, and help ensure that all steps of a task are understood.

- A specific praise / reward system that can be monitored visually by would encourage him to maintain a high level of concentration, self-esteem, and motivation to learn. He could share this with his family and his interest's can be used as part of the reward system.

- Provide outlines that are clear and not visually overwhelming. Written outlines facilitate organisation and alleviate the frustration of copying from the board or taking copious notes.

- Provide direct instruction in social skills. Teaching how to recognise and understand facial expressions, body language, and emotions. Social competence can be taught through role playing, but can best be addressed through a curriculum designed to teach social skills such as Secondary SEAL materials.

- Provide with opportunities to interact with his peer group in order to encourage leadership roles and instil a sense of responsibility.

- will benefit from collaborative goal setting so as to ensure clarity on expectations for him at school.

Date of next review:

Name of recorder: Zobiah Akthar
Job title: Trainee Educational Psychologist

Signature:

Date:

Countersigned by: [redacted]

Job title: Senior Educational Psychologist

Signature:

Date:

Area/Office contact address:

[redacted]

CC: Parents
CC: School, [redacted]
CC : File

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PROFESSIONAL PRACTICE REPORT THREE

Multi-agency working: What this means in practice for professionals and outcomes for children in Local Authorities: An Educational Psychology Perspective

Abstract

This paper seeks to explore the government agenda and policy regarding collaboration between local authorities (LAs) and other agencies, such as health and community based professionals. There appear to be a number of different terms that describe this collaboration including "multi-agency", "integrated services", and "coordinated working" (see Table 1, p. 2, for brief definitions). There are four sections to this paper and they are discussed briefly below.

Within the first section, there will be an exploration of the various terminologies and how these impact on professionals who are taking forward the government agenda, and whether the legislation/policy and theory apply successfully to everyday professional roles and modes of working.

The second section is a brief summary of psychological theories relating to multi-agency practice and the implications for the role of the educational psychologist (EP).

Thirdly, the paper will discuss the growing body of research which evaluates the effectiveness of working collaboratively to support children and young people, and what the advantages and disadvantages are of working in this way.

Finally, the paper will discuss how a local authority's (LA's) Children, Families and Education (CFE) Directorate have implemented the government agenda, and how this works on a day-to-day basis with regards to protocols, referrals, professional roles and responsibilities. Furthermore, this paper will follow an individual case study through the

(CFE) multi-agency framework known as the Partnership Based Review (PBR); a monthly meeting of multi-agency professionals where individual cases are discussed and resources are allocated.

The author will conclude by identifying whether this process has achieved the positive outcomes intended by the government's *Every Child Matters* agenda (2003), and by the CFE professionals, regarding delivering the appropriate services to support vulnerable children and their families.

Terminology and defining working practices

Throughout the policy and legislation analysis within this paper, there appear to be numerous terms to describe "joined up working" or "collaboration." Particularly within current policy and practices, there appear to be many terms that describe the joining up of services and professional collaboration to promote positive outcomes for children and families. For example, Soan (2006) talked about policy documents such as the '*Every Child Matters: Change for Children*' (DfES, 2004a), where the terms 'multi-agency', 'lead professional', 'multi-disciplinary', 'integrated services' and 'inter-agency' are all used within 3 pages of the document, with all appearing to be used interchangeably.

Lasker, Weiss and Miller (2001) used the term 'partnership' to include collaboration which brings people and organisations together in order to improve health and wellbeing for children and families. Hallam, Castle and Rogers (2004) described it as aiming to maximise the benefits of cooperation by working with others.

There are some questions raised regarding the various terms in use. For example, it could be confusing for parents and professionals who are not familiar with these terms to know whether each term means the same thing or whether it is something different. The language used can mean different things to different professionals, parents and children and is open to many different interpretations. Therefore, different services see multi-agency working differently, creating inconsistencies in service models across the country and even within one local authority.

Bearing this in mind, the government still appears to use 'multi-agency working' as their main term for partnership working (defined in Table 1 below). This terminology suggests that there could be a danger of professionals and authorities focusing entirely on working together, which could take away from the reason for joint working in the first instance, which is to ensure that the delivery of public services is meeting the needs of the public and not the needs of the public service providers (Hughes, 2006).

Hughes (2006) pointed out that before we are able to see if multi-agency working is able to provide a solution to the identified problems, it is important to understand what constitutes multi-agency working.

Townsley and Watson (2004) stated that one of the most pragmatic definitions of multi-agency or partnership working was given by Leeds Health Action Zone (2002) which described 'a partnership as two or more people or organisations working together towards a common aim'.

Bearing in mind the issues with terminology, the author of this paper has identified a few key definitions based on a number of definitions provided by researchers in this field. These include:

Table 1

Terminology	**Definition**
Multi-Agency Team (MAT)	A defined structure or model which sets out how multi-agency working would work, a degree of resources sharing including staff time, and/or money to provide services and a multi-agency steering or management group (Watson, Abbott & Townsley, 2006).
Integrated Services	Services are synthesised and coordinated and offer a more holistic approach where the focus of service delivery is the child and family. Funding is multi-agency and professionals operate as a team (Townsley & Watson, 2004)
Coordinated Working	This implies some coordination of service provision and occurs when individual professionals from different agencies assess separately but meet together to discuss their findings and set goals (Townsley & Watson, 2004).

Legislation and policy regarding multi-agency working

The multi-agency working agenda is a key feature of the current government's approach to social policy and the modernisation of public services (Watson, 2006). The need for collaborative working practices is an important theme that runs through many legislative papers from education, health and social services over the last decade: for example, in several White Papers including the Department of Health 1997, 2001 and Cabinet Office (1999, cited in Watson 2006).

Multi-agency working became a policy imperative when the Labour government promoted the idea of 'partnerships' as an alternative ethos to the internal market and competition in services (Alexander & Macdonald 2001). Current legislation requires professionals to find ways to move across the boundaries between health, education and social care.

However, this drive for joint working is not a recent government movement, as it may often be perceived, but instead has been highlighted by research in earlier documents too. For example, in 1998 Payne put forward an argument for multi-agency working within local authorities:

'The case for treating social problems in a holistic fashion is overwhelming. People know, in simple every day fashion, that crime, poverty, low achievement at school, bad housing and so on are connected' (p. 12).

Prior to the inclusion debate, Bronfenbrenner (1970) commented that he felt it was vital for a national approach to joined-up collaborative working. He stated that:

'It is a sobering fact that, neither in our communities nor in the nation as a whole, is there a single agency that is charged with the responsibility of assessing or improving the situation of the child in his total environment. As it stands, the needs of children are parcelled out among a hopeless confusion of agencies, no one is concerned with the total pattern of life in the community' (p. 163).

Six years on from Bronfenbrenner's (1970) comments, The Court Report (DHSS, 1976) emphasised the importance of practitioners working with parents, and of them seeking guidance and support from other professionals if it was in the interest of the child. This was subsequently reinforced by the Warnock Report (DES, 1978) which stated that inter-professional working should support children with special educational needs (SEN), including children with social, emotional and behavioural difficulties (SEBD), by identifying, monitoring and reviewing interventions collaboratively.

Following on from this, the Children Act (1989) took the need for collaborative practice a step further by making it a local as well as a national issue through the introduction of collaborative policies led by the Department of Health. Leading on from this, raising the profile of collaborative practices for the wellbeing of children, The 1996 Education Act (HMSO, 1996) started requiring schools and social services, local authorities and health agencies to share information. Subsequent government policies such as the SEN Code of Practice (DfE, 1994; DfES, 2001) and the National Curriculum Inclusion Statement (QCA, 1999) continue to enforce the government's desire for joint working amongst professionals.

However, research conducted on multi-agency collaboration in the 1990s, such as that by Pearce and Hillman (1998), and Dyson and Milward (1997), suggested that agencies and professionals were unsuccessful in implementing these policies. Furthermore, it was highlighted by Stead, Lloyd and Kendrick (2004) that research into collaboration lacked durability and many examples of it did not work out in policy or in practice (p. 42). They argued that the lack of funding, lack of clear policy and structure means that these above named issues such as fragmented services and lack of clarity will continue to arise from front line staff.

Moreover, recent research, such as that by Pettit (2003), Hallam *et al.* (2004), and Sloper (2004), has suggested that the research findings above can be viewed as "teething problems". These more recent studies found that there are some common positive outcomes for children, families and schools. These include improved behaviour, enhanced relationships with service providers, parents and other adults, improved access to education and enhanced emotional and social wellbeing, especially relating to confidence and self-esteem (Soan, 2006).

When looking closely at these studies it can be noted that they appear to have focused on the professional views of positive outcomes. Overall there appears to be a lack of robust research which focuses on any one model of multi-agency working. There also appears to be many models and practices that come under the umbrella of multi-agency practice. Therefore, it is difficult to identify which model or aspects of professionals working together is the most effective for gaining positive outcomes for children and young people. Much of this research can be viewed as misleading, particularly as the authors do not give any clear definition of what multi-agency working is like.

Nevertheless, recent changes in government policy, and attention on public services by the media, due to serious child protection flaws and gaps in professionals' sharing of information, have prompted the need to lift multi-agency working once again to the top of the agenda for local authorities (Watson, 2006). This is largely based on The Laming Report (HMSO, 2003), an official inquiry into child protection services provoked by the death of Victoria Climbie. The outcomes of The Laming Report prompted the government to drive policy and legislation regarding vulnerable children into the forefront of public service policy and agendas.

This agenda was largely directed through the publication of the Green Paper *Every Child Matters* (Department for Education and Skills, 2003) which proposed major changes to health, education, and social services with a focus on improving and safeguarding the wellbeing of "vulnerable children" and their families. The policy outlined steps for whole system reform for all children services in the forthcoming years. Five outcomes for children and young people were derived through consultation with them. These included: Enjoy and Achieve, Be Healthy, Stay Safe, Make a Positive Contribution and Achieve Economic Wellbeing.

Within the publication of the Green Paper *Every Child Matters* (DfES, 2003) there was also a clear theme arising for multi-agency working and it acknowledged that this would be a challenging time for professionals. The common core framework to *Every Child Matters* (2003) suggests that 'skills' of assertiveness, communication and teamwork are important along with 'knowledge' of the role and remit, policies, procedures and working methods. The government saw developing more integrated services to improve outcomes for children and young people as a key strategic challenge, suggesting that fragmentation and 'working in

silos' can result in uncoordinated and less effective support for families, as identified by the findings of the Lord Laming Report.

The *Every Child Matters* agenda (2003) made it clear that the safeguarding of all children was not the responsibility of any one agency, but the responsibility of many professional agencies working together with a common goal/outcome (to support the ECM agenda, 2003). Although this was disseminated to all public service agencies, local authorities (LAs) appear to be taking this forward in a piecemeal fashion. However, there appears to be no one model

that all local authorities are following. An example of a model is discussed later in the paper.

Psychological perspectives of multi-agency working

There is some research which looks into the psychological perspectives of multi-agency practice. One contribution discussed in the literature is the work on socio-cultural perspective and activity theory (Leadbetter, 2006). Wertsch *et al*. (1995, p. 3, cited in Leadbetter, 2005) stressed that there are many approaches to socio-cultural work, and attempted to summarise its key principles by stating:

'The goal of a socio-cultural approach is to explicate the relationships between human mental functioning, on the one hand, and the cultural, institutional, and historical situations in which this functioning occurs, on the other' (Leadbetter, 2005, p. 2).

Activity theory, which is a social-cultural perspective, sets out to understand human activity. Authors such as Leadbetter (2006, 2005) have argued its use in the work of educational psychologists and in understanding complex systems at the macro and micro level.

Essentially, activity theory theorists argue that most human behaviour should be considered as purposive and their actions culturally meaningful rather then reactive or adaptive responses to environmental and behavioural stimuli (Kozulin, 1998, cited in Leadbetter, 2005), suggesting that systems do not just exist on the basis of changes in their environment but have a purpose and meaning beyond this linked to culturally specific experiences past and present. Kozulin (1998) claimed that:

'Activity then takes the place of hyphen in the formula S-R (stimulus-response), turning it into the formula subject-activity-object, where both subject and object are historically and socially specific' (1998, p. 13, cited in Leadbetter, 2005, p. 21).

A lot of the work discussed in the literature on activity theory links to the work of Engeström (1987), citied in the work of Leadbetter (2005) and Daniels (2005). Engeström described the development of activity theory as falling into three generations:

- The first element comprises of a triangle linking the subject and the object through a range of meditational means.

- The second element of activity theory emphasises the importance of the study of artefacts and mediation.
- The third element is where Engeström expanded the triangular conception of an activity system to include a much wider 'macro-level' analysis that focuses on the collective and communal factors. This is where he introduced the notions of 'rules', 'community' and 'division of labour'.

Engeström (1987, cited in Leadbetter, 2005) emphasised the importance of the interaction between the various elements within this expanded activity system, and also the importance of the constant changing of the subjects and objects. For a more detailed description of the origins and details of activity theory, see the work by Daniels (2005) (for a full diagram of an activity system, see Appendix 1).

Leadbetter (2005) suggested that activity theory provides psychologists and researchers with an opportunity to analyse human behaviour, through understanding individual interactions within wider systems. It particularly links to the work of educational psychologists as they move away from individual child focused models of working to wider systems of communities, institutions and organisations, such as LAs.

Leadbetter (2005, 2006) demonstrated in her research a number of ways in which activity theory can explain the work of EPs. These include a consultation with a school teacher, a peer tutoring project and the roles and functions of professionals with a MAT (for a full summary of activity theory in EP practice see Leadbetter, 2005).

Role of EPs and implications for future practice

Like the debate on the effectiveness of MATs and the links with outcomes for vulnerable children, there is also a growing debate about how best educational psychologists can use their skills in consultation, understanding of organisations, and systemic thinking to promote positive outcomes through MATs.

Turner and Stringer (2004) feared that the emphasis on ensuring swift and coordinated responses to referrals may make it difficult, for educational psychologists in particular, to invest time, energy and expertise in more preventative approaches. They see the emphasis on individual referrals as leading to a potential 'gate-keeping' and access role to professionals in Children's Services based on 'eligibility criteria'. This in turn could lead to over-bureaucratisation in comparison to the consultation approach to service delivery that many educational psychology services have developed. They also suggested that if psychologists get their contribution to professional teams right, through good management and supervision, psychologists could become rich, diverse and complementary members of teams (Hymans, 2006).

Leadbetter (2006) discussed how many EP services are committed to and enthusiastic about consultation and argued that the challenge is to consider how its use can be transferred as working practices change. There are a number of issues that arise and that need addressing by services as they transform if they are to develop their skills rather than bury them.

Squires, Farrell, Woods, Lewis, Rooney and O'Connor (2006) reviewed the contribution EPs made to the *Every Child Matters* agenda and within this found that out of the 95 cases surveyed, only in five was the EP the sole agency involved, suggesting that the role of the EP involves liaising with many different professionals. In their survey, when asked if the EP liaised with other professionals, the list was extensive. However, when looking in more detail at the data, SENCos and others – i.e. other school professionals - were the most commonly cited professionals EPs liaised with; nearly twice the number of times as other professionals, suggesting that the EPs' role is still predominantly linked to school professionals. However, youth offending teams (YOTs) and social workers were cited 14 times, suggesting practices

are moving (no previous figures are offered in the paper, therefore a comparison cannot be made) towards working with professionals who work directly in the community.

Overall it appears that the role of EPs within MATs is diverse and still evolving. They are placed in a unique position as their skills of critical reflection and understanding of psychology, and in particular group dynamics, allow them to continually identify the purposes and usefulness of multi-agency working. As stated by authors such as Farrell *et al.* (2006), facilitating multi-agency working appears to be essential in the EPs' remit for the future.

Research into multi-agency working

The need for multi-agency working between health, education, and social services has been highlighted by numerous studies, e.g. Biehal, Clayden, Stein and Wade (1995), and Webb and Vulliamy (2001). However, research such as that by Watson *et al.* (2002, 2006) continually points to a lack of coordinated multi-agency working, the scarcity of key workers in services (especially social services), and the fact that services for children remain fragmented.

A wide variety of structures, approaches, and rationales have been adopted across the country, attempting to implement the policy directives and move towards integrated services (Atkinson, Doherty & Kinder, 2005). Most local authority approaches include trying to ensure that the services are coordinated at the point of delivery to children and families through establishing co-located multi-agency teams (Watson, 2005).

Studies such as that of Atkinson *et al.* (2005) have been conducted, which look into a number of teams that have been established with professionals from different agencies including health, education and social services. They collected data from a sample of 30 multi-agency initiatives which were chosen to reflect the range of target group focuses and different agency involvement, as well as different contexts. They put forward five models based on their research which included:

Table 2: Models of multi-agency working

Model	**Purpose**
The decision making group	To provide a forum whereby professionals from different agencies could meet to discuss issues and to make decisions.
Consultation and Training	For the professionals from one agency to enhance the expertise of another by providing consultation and/or training them.
Centre-based delivery	To gather a range of expertise together in one place in order to deliver a more coordinated and comprehensive service.
Coordinated delivery	To draw together a number of agencies involved in the delivery of services so that more coordinated and cohesive responses to need could be adopted.
Operational team delivery	For professionals from different agencies to work together on a day-to-day basis and to form a cohesive multi-agency team that delivered services directly to clients.

In their research, decision making and coordinated delivery were the most frequent types of multi-agency activity encountered within the sample, whilst operational team delivery was the least frequent. These models suggest a variation in initiatives and practice that are operating under the name "multi-agency".

Atkinson *et al.* (2005) suggested there might be value in further refining how these are described in order to ensure a better understanding of multi-agency processes and how these relate to successful outcomes.

However, questions still remain, which include how the teams operate on a day-to-day basis and how the structure and organisational changes for all professionals are implemented. This has implications for the research in this field and its generalisability as there is still no clear

model of MATs and it is not clearly defined in regards to resources, the sharing of expertise and managerial structure.

Watson (2006) conducted a study of 52 professionals working in a multi-agency setting and identified important factors in multi-agency team development and concluded a number of themes important for facilitating multi-agency working. These include:

- Shared vision
- Realistic aims and objectives
- Co-located teams would benefit from external agency support by way of professional time, resources, expertise and training, etc.

Once again, due to the study's single case study design the findings are limited as they cannot be interpreted for wider LA generalisation.

Research, such as that by Hallam *et al.* (2004) and Sloper (2004), has highlighted similar findings and states that many multi-agency teams (MATs) that have been newly established can experience teething problems. As identified by Watson (2005), the nature of MATs themselves is taking professionals away from their current roles and responsibilities and, to a certain extent, redefining them within a multi-agency context. This in itself brings out issues of professional identity and general issues of location and management.

The advantages and disadvantages of collaborative practices

This section of the paper focuses on research findings and how they have identified strengths and weaknesses associated with multi-agency working. Wistow and Harday (1991) documented the difficulties arising from professional collaboration. They identified five significant obstacles to inter-agency working. For example:

- Structural - lack of co-terminology
- Procedural
- Financial

- Profession
- Status and legitimacy - threats to autonomy

Wistow and Hardy (1991) concluded that individual referrals could lead to the potential gate keeping of services and the role of professionals in children's services could be based on eligibility criteria rather than a consultation approach to service delivery.

Although the above source is dated, researchers such as Watson (2006) would argue that some of these obstacles still remain. Some similarities regarding roles and responsibility, financial implications and lack of co-terminology still remain (as highlighted in the study by Atkinson, Wilkin, Stott, Doherty and Kinder (2002) below). However, Watson (2006) stated that recent government legislation, such as the *Every Child Matters* agenda (2003), may create further obstacles relating to information sharing and role overlap.

A detailed study by Atkinson, Wilkin, Stott, Doherty and Kinder (2002) on multi-agency practices, where 139 professionals were interviewed, highlighted challenges to collaborative working, and included information gathering and sharing, staff training and geographical issues as the key issues associated with successful collaboration. This study raised a number of methodology questions; for example, have the results measured successful collaboration through the eyes of professionals or through achieving positive outcomes for children and young people? This isn't clear from the study, and it is also limited to discussing professionals' views regarding collaboration. Further information from the point of view of services users about the effectiveness of collaborative teams would need to be explored in order to understand the true effects of this mode of working.

Sloper (2004) detailed factors facilitating multi-agency teams (MATs) and acknowledged difficulties at the organisational level. These included concerns regarding planning, implementation and management style. They then identified ways in which multi-agency practice can be promoted. These include:

- Clear and realistic aims and objectives that are easily understood and accepted by all
- Clearly defined roles and responsibilities with clear lines of accountability
- Commitment of both senior and frontline staff

- Strong leadership and a multi-agency steering or management group
- Ensuring good systems of communication and information sharing at all levels
- Agreed timetable and incremental approach to change

(Sloper, 2004)

Sloper (2004) suggested that the implementation and ongoing management of MATs requires shared and adequate resources, the recruitment of staff with the right experience and knowledge, joint training and team building, appropriate support and supervision for staff and monitoring and the evaluation of service policies and procedures.

These findings add weight to much of the literature that is available on MATs, such as the work by Hughes (2006), Watson (2006), and Atkinson *et al.* (2002). Sloper's (2004) findings are not surprising as once again clear roles and responsibility, effective information sharing and communication, and the need for structure at the organisational level appear to be key aspects to enabling MATs. From the author's own experiences of working within a MAT, a key observation noted included at times the lack of clarity from the management team and the organisations' unclear protocols. This resulted in unclear roles and responsibilities for many of the professionals within the team.

Frost (2004) carried out a research project funded by the Economic and Social Research Council (ESRC) on MATs**.** He researched five diverse and well established MATs. He used an ethnographic approach to data collection which included observations and semi-structured interviews to identify and conceptualise good practice in MATs. The findings included structures and systems, professionals' own beliefs and ideologies, professional knowledge, inter-professional team building and individual recognition. However, this paper can be critiqued on the methodology, as conducting participant observations can impact on the results obtained. Despite the methodology concerns, the findings reflect much of the work that has already been documented. Therefore, it highlights some clear themes emerging from the research regarding what a successful MAT should consist of; for example, organisational structure, shared goals, and clear roles for professionals.

Hymans (2008) also highlighted how professional identity can act as a barrier to multi-agency working. He elicited core constructs of all team members of a multi-agency team around their

own perceptions regarding their professional role in the team and also how they thought others in the team perceived them. Using Personal Construct Psychology, Hymans (2008) then asked professionals to categorise these into bi-polar constructs. The results highlighted four super-ordinate bi-polar constructs which were placed in the following themes:

Structural: relating to uncertainty about the purpose and role within the team, and the opposite construct being everyone knowing everyone's role and how this fits together.
Ideological: Working towards a common goal versus working to a different agenda.
Procedural: Using intervention-based approaches versus using assessment-based approaches.
Inter-professional: Preventative work versus being engaged in crisis management.

(Hymans, 2008)

This study provides a useful approach to eliciting professional views on professional identity to support multi-agency professionals in establishing and promoting a common language and a shared vision. However, as the study is based on a single multi-agency professional team the findings are not generalisable to other MATs.

Within the research on MATs, there is also a large body of research that discusses the difficulties of working collaboratively. Axford, Little and Morpeth (2003) referred to a strong thread of evidence which points to the problematic nature of inter-professional collaboration and the use of different terms, most of which imply working together as a harmonious activity with a focus on consensus.

Visser (2003) noted that while many documents emphasise the need for change in professional roles in order to provide effective coordinated input for children and families, even where support is good, it appears to be down to a few key people at local levels. Professionals, who have been through a number of organisational changes, may be less forthcoming about changes to job roles; therefore causing barriers to effective working.

Dunsmuir, Clifford and Took (2006) conducted a study which investigated the perspectives of EPs and speech and language therapists (SPLTs) on collaborative practices across two services. This study was prompted by national statistics regarding the level of speech and

language need by many children at early ages and the important role speech and language assessments play in provision for children who have special educational needs (SENs), particularly children who are also being assessed by an EP.

The themes identified through this study included barriers to collaboration such as a lack of understanding of roles and different perceptions about professionals; for example, differing views on the use of cognitive assessments, particularly their use with children who have language difficulties. Also highlighted were issues around sharing of information, and differences in professional thinking, which were highlighted in similar findings, such as those by Dessent (1996).

These issues relate similarly to other professional groups and studies which discuss barriers to multi-agency working. Dunsmuir *et al.* (2006) suggested inter agency training, better methods of communication, and enhancing the knowledge of school systems for non-educational professionals, such as speech and language therapists (SPLTs), as ways forward.

Axford, Little and Morpeth (2003) note that inter-agency analysis shows that at the point of service delivery few children benefit from inter-agency cooperation, with one agency usually carrying all the responsibility. This statement is open to a number of criticisms as many public services are still developing practices to meet the government's policies. Much of the literature focuses on LA children's services departments. Health services and voluntary agencies are not equally represented in the data and, therefore, it can be hard to comment on these services. However, based on the available research, such as that by Axford *et al.* (2003), there are many circumstances (such as a SEN concern) when a single agency does appear to be the key driver in delivering services. This could be largely due to professionals' understanding of the role of the 'lead professional' (discussed below).

The government policies in developing more effective protocols for supporting and safeguarding vulnerable children call for LAs to support the implementation of 'Team around the Child' (TAC) meetings within which a 'lead professional' is allocated to coordinate them.

The role of the lead professional involves:

- Acting as a single point of contact that the child or young person and their family can trust, and who is able to support them to make choices and help them navigate their way through the system
- Ensures that the interventions are appropriate to the families needs and that they are regularly reviewed
- Reduces overlap and inconsistency between professionals

(ECM, 2003)

Due to the nature of the children and families who may require this type of support, many lead professionals may be educational service professionals. Due to shortages within social care, often the social worker is not able to take on this role. Educational psychologists are often highlighted within documents as professionals who can take on this role. From the author's own experiences it appears to be varied as to who takes on the role of the lead professional.

Warren House Group (2004, p. 8) criticised the ECM agenda (2003) and argued that reforms such as this are in danger of perpetuating the assumption that modifying the structure of services will result in a change of culture, and that this cause and effect relationship is not supported by much evidence. This statement is not necessarily supported by the research highlighted above, such as that by Atkinson *et al.* (2002) and Watson (2006), as they found that shared goals and visions were crucial to successful practices, which the ECM agenda (2003) does provide for professionals who are working together.

So far this paper has focused predominately on research, legislation and polices which highlight the need for better joined-up professional working, which aims to help promote better outcomes for children and their families. Elements identified as important to successful MATs, and some of the barriers to achieving these, are also outlined.

However, there are still a number of key issues remaining. These include outcomes for children and young people. There is still no clear evidence base which identifies that better outcomes have been achieved for children and their families, which should result from MATs.

Although the clear driver for MATs appears to be the evidence provided by serious case reviews, for example Axford and Bulloch (2005) noted that the common practice shortcomings include the inadequate sharing of information and a lack of inter-agency working, 30% of the children subjected to serious case reviews annually in England (2004-2005) were virtually unknown as children in need. It is still unclear whether this situation is any different at the moment.

Soan (2006) discussed the effect that the recent policy and legislation has had on services for children and young people experiencing social, emotional and behavioural difficulties (SEBD), particularly 'Looked After Children' (LAC). After an analysis of two case studies of LAC children's experiences of the education system, Soan (2006) concluded that in some LAs decisions are now made using many, if not all, of the good practice guidance relating to collaborative working for many children.

Soan (2006) suggested that an investment in time, professionals' expertise, funding, and a common purpose/goal will help to promote positive outcomes for children and young people through a multi-agency approach. However, further research into the views of children and their experiences of MATs and how this affects the outcomes for their lives is still scarce.

One such paper that did look into the views of children was the work of Watson *et al.* (2006). They conducted a three year research study into multi-agency services for children with complex health needs; the authors involved the children in a variety of different ways and endeavoured to discover what impact, if any, multi-agency working made to their lives.

The paper was about engaging children with complex health needs in research and they defined multi-agency practice as services with key components of multi-agency working, such as:

- A defined structure or model which sets out how multi-agency working would work
- A degree of resources sharing including staff time and/or money to provide services
- A multi-agency steering or management group

Further analysis of the data suggests that the authors sought children's views on relationships with professionals, and they found after interviewing 18 children with a variety of needs that

children did value professional input. Overall the children did not find seeing many different professionals a difficulty, but found professionals not being able to get to know the children difficult; many did not have much contact with their key worker. Until services are adequately funded to allow time to build relationships, or have contact, it is hard for children to feel heard. Although this study provides useful information on the views of children and young people, it does not directly look at the impact of a MAT. It does offer views on service users and their relationships with different professionals. However, it does not offer any research on the coordinated professional team. Much of the data is linked to views about individual professionals.

Partnership Based Review (PBR) Evaluation

Background information to the analysis of the South West Locailty PBR

Background

This section of the paper focuses on the author's evaluation of the local arrangements based on the government agenda to create more joined-up services and more effective collaboration between professionals to benefit the future outcomes for children and young people. This evaluation is based on the ***** Children, Families and Education Directorate's roll-out of "partnerships", which refers to locations around *****. For example, the author's "partnership" was ***** ****. Within the ***** LA, professionals and services are located in these smaller locality based "partnerships", and the ****** West team covers a patch of 32 schools. Within each partnership agencies include Educational Psychology, Specialist Teaching Services, Family Action, Tier 2 Child and Adolescent Mental Health Services (CAMHS), some voluntary agencies such as Adolescent Resource Centres (ARCs), and a link social worker (a new post created to link the partnership team to social services).

The partnership manager's professional background is social care and is responsible for developing and promoting the policy initiatives within the Local Authority partnership, linked to guidance set out in documents such as the Green Paper (DfES, 2003). These policies and agenda link to the government policies of creating a Single Point of Access (ECM, 2004a) and a co-ordinated and multi-agency response to the needs of children and families.

Within Dartford West the partnership began to implement these policies by developing the Partnership Based Review (PBR). This is a monthly multi-agency meeting where professionals, parents or schools can refer a child about whom they are concerned in regards to their education, emotional well being or care. The PBR has a referral form and guidance to support referrers on the process about when and how to refer a child.

Training and support was offered to schools and professionals regarding this process, and within ******* West this was the only process of referring children and families to access

specialist support, thereby creating a single point of access. The hope was to promote better coordinated services so that children who came through the PBR system would have a link professional who could signpost the child and family to appropriate services and monitor the outcomes for the child and family; therefore, potentially creating a more preventative service where children were monitored and not lost in the system, as had previously been the case.

After a year of the PBR being implemented, the Trainee Educational Psychologist (author of this paper) was commissioned, in collaboration with the ****** West Senior Educational Psychologist, to undertake an evaluation of the PBR process.

The evaluation aims included:

I) To identify the views of schools that use the PBR service

2) To gain a wider perspective from professionals who are involved in the PBR on how they have found the process of working collaboratively with other professionals

3) A case study of a child with social, emotional, and behavioural difficulties (SEBD) who had been through the PBR process

Method

Questionnaires were used as the method of quantitative and qualitative data collection. There are a number of advantages and disadvantages to collecting data in this way, which include:

- They reach a large geographical area
- People are more used to completing paper-and-pencil surveys
- Can take the survey with you and complete it anywhere and anytime
- Can work well for sensitive issues

The disadvantages include:

- No clarification available during completion
- Need a motivated population to return the survey (people have too much to do)

- Respondents must be able to read, see and write

(Cohen & Manion, 2007)

Due to the large number of schools the evaluation wanted to target - 32 schools are in the partnership - individual interviews were not feasible within the timescales of the evaluation. Therefore, the decision was made to use a questionnaire. Semi-structured interviews were conducted to support the questionnaire data, but this was with three schools who had answered ambiguously on a number of questions. This approach was used as it provided further elaboration by participants about the particular comments made within the questionnaire.

A questionnaire designed by the Senior Educational Psychologist (appendix 2) was sent to all 27 schools within the ***** West Cluster. The focus of the questionnaire was the process of the Partnership Based Review (PBR). Questionnaires were sent out with a request for completion within a four week time scale; two follow up phone call reminders were made thereafter. In total, 13 schools responded to the questionnaire, with 12 completing the questionnaire completely and 1 school part-completing.

Once questionnaires were returned, the Trainee Educational Psychologist (TEP) contacted schools which had not responded to the survey by telephone. Out of the 8 schools contacted by the TEP, 3 responded. These schools participated in a semi-structured interview by phone regarding the PBR process.

Semi-structured interviews were used as a method of data collection as the researchers wanted to gain a richer and deeper perspective from PBR users about their experiences, which was not necessarily available from the questionnaires. It also provided the researchers with the opportunity to gain more detail on some of the questions answered by the participants in the questionnaire. However, the researchers were also aware that semi-structured interviews can often create a bias towards the researcher; participants may have not been entirely honest in their views about the PBR process as the person interviewing them was linked to the PBR.

Questions 1 to 7 of the questionnaire consisted of a series of positive statements about the PBR process, about which respondents were asked if they strongly disagreed, disagreed,

agreed or strongly agreed. In addition, each questionnaire included two open questions about the strengths and weaknesses of the PBR process. This was supplemented with data obtained from three semi-structured interviews with SENCOs in the Dartford West schools.

Results

Quantitative analysis of questionnaire data

13 out of 27 schools responded to the questionnaire (3 secondary and 10 primary schools). An analysis of the statements which elicited a positive response ('agree' or 'strongly agree') and those which elicited a negative response ('disagree' or 'strongly disagree') suggested that overall respondents were positive about the PBR process. 80% of the questions were answered positively (this is represented in Figure 1 below).

Figure 1: Overall responses to questionnaires

The pie chart below highlights that most schools responded positively to the PBR process.

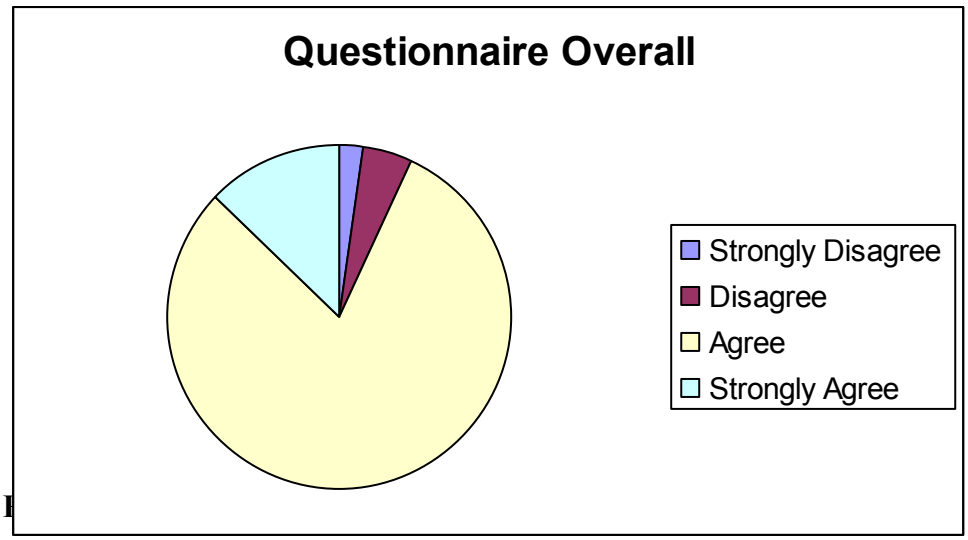


Figure 2:

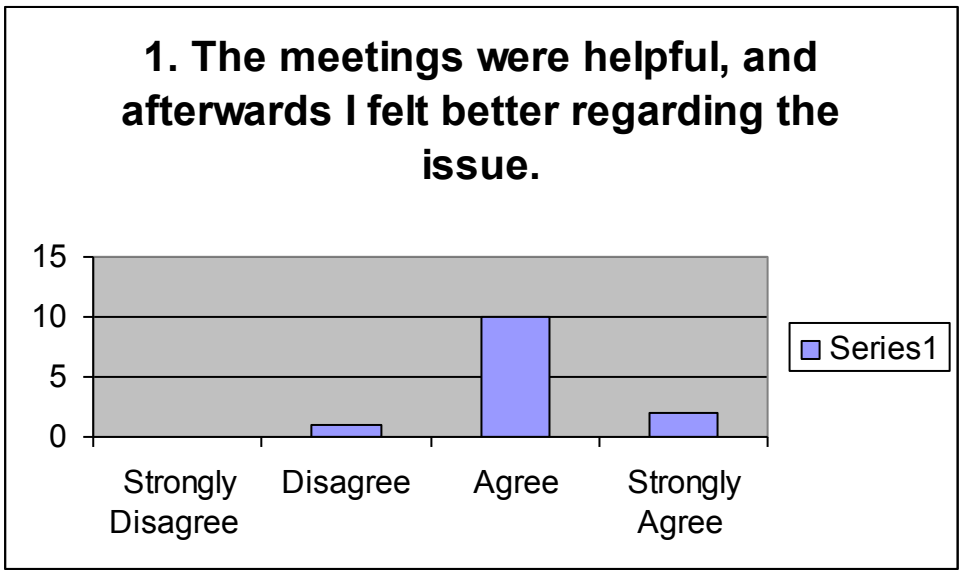
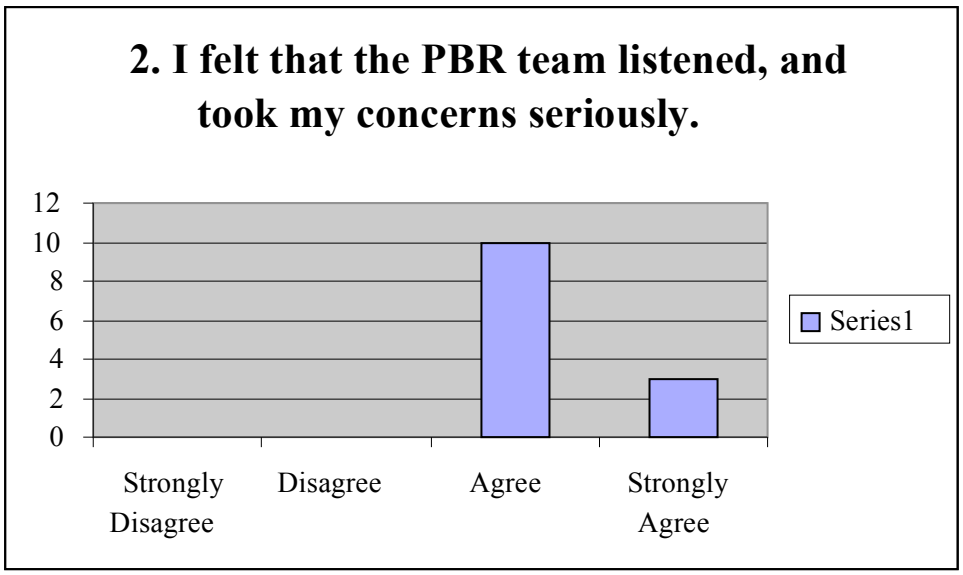


Figure 3:



All respondents felt that the PBR team listened to their views and responded positively to their concerns. 10 respondents agreed with this statement and 3 strongly agreed.

Figure 4:

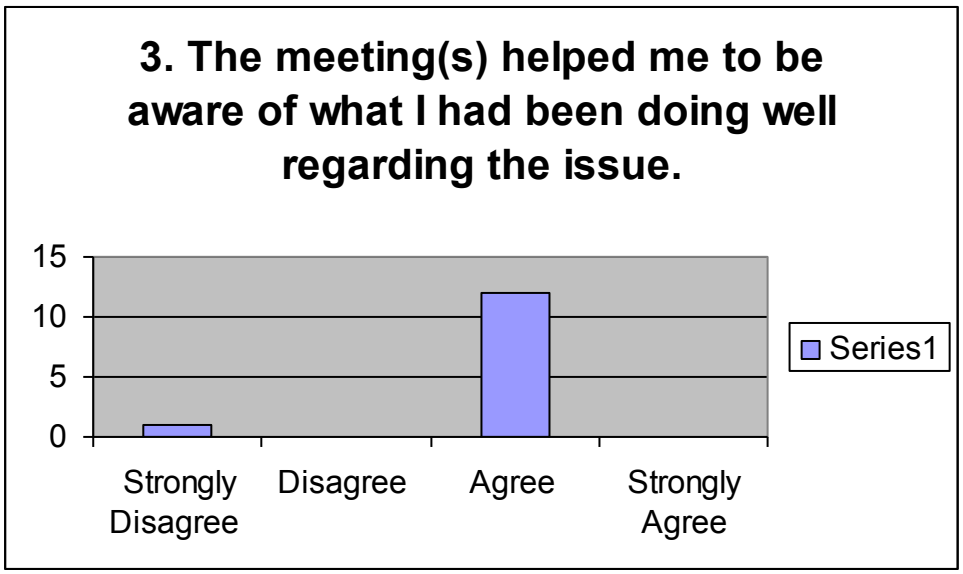
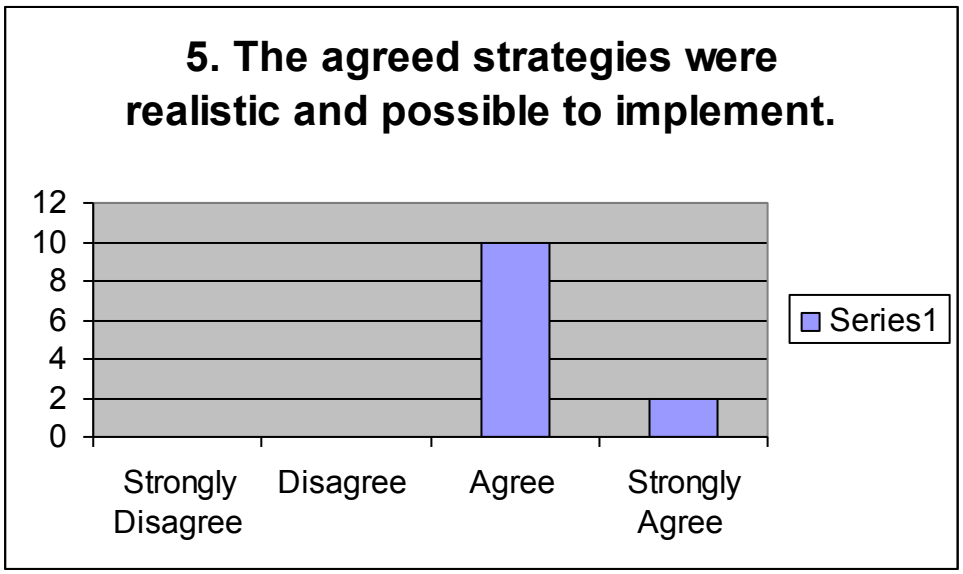


Figure 5:

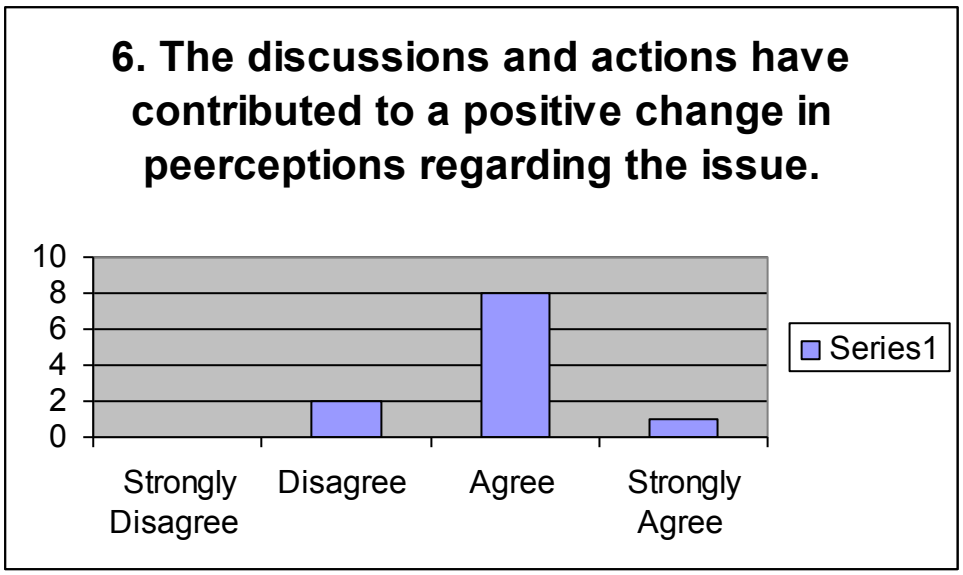
All respondents felt that the PBR consultation provided them with a way forward and practical strategies, ideas, and actions that they could implement as soon as possible.

Figure 6:



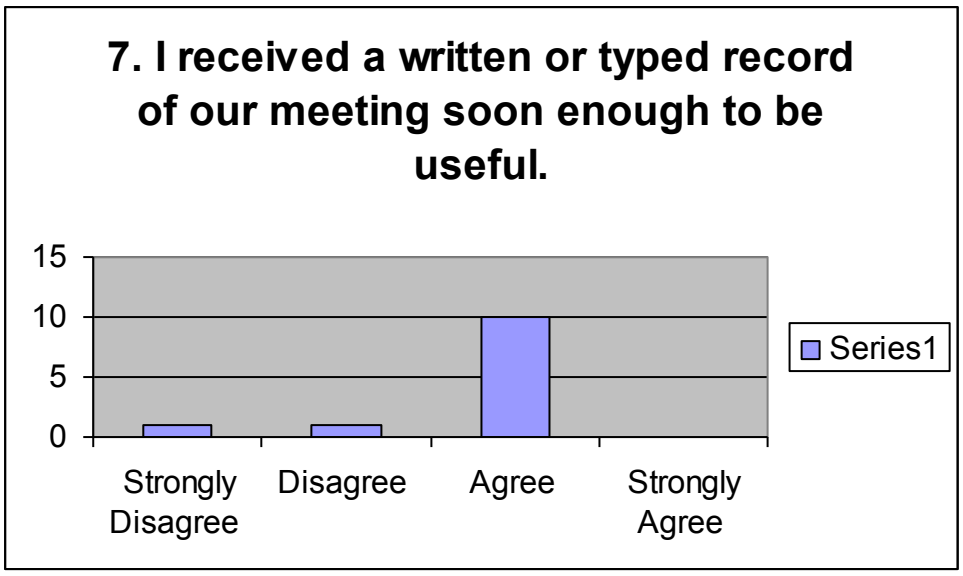
This result highlights that all 13 respondents felt that the advice offered by the PBR team was realistic and appropriate for the schools to implement.

Figure 7:



Although the majority of respondents felt that the contributions offered in the PBR meeting helped change perceptions regarding the issues, two schools felt that this had not been the case.

Figure 8:



Overall it seems from the results that Question 6 (regarding a positive change in perceptions) and 7 (receiving a useful, written record of a meeting) elicited the most ambivalent responses.

Qualitative analysis of questionnaire and interview data

A thematic analysis was carried out to analyse the 3 semi-structured interviews and questions 8 and 9 from the initial questionnaire.

Braun and Clark (2006) suggested that thematic analysis is widely used informally in the world of psychology research, but they also suggested that there is no clear agreement about what thematic analysis is and how you go about doing it. This approach of data analysis was chosen by the researchers because of its flexible and time efficient approach.

The following themes emerged from this analysis.

Theme	**Total**
A lead professional who can liaise more regularly with the school	1
More support for children with MLD	1
More collegiality between professionals within PBR	1
More time for complex cases	1
Shorter timeframes between times of referral to actual meetings	9
The level of paperwork to be reduced	1
Recognition of good practices for schools that have already identified and supported children with difficulties	1
Guidance and procedures to become available on cluster web	1

Table 3:

Question 8: **Thinking about your experience of the PBR Team last academic year, what has worked particularly well?**

Question 9: **From your experience of the services received, please identify areas for further improvement in actual service delivery.**

Table 4:

Theme	**Total**
Accessibility to the PBR team	5
Opportunities to hear different professional views	5
Advice is valuable and "ways forward" discussions are particularly useful	5
Having support from appropriate professionals is empowering and positive	11
Opportunities to get to know the different professionals and their roles	4
Positive outcomes for children and parents	3
The Rapid Response service was a positive experience	2

Overall the feedback received from the semi-structured interviews and analysis of Questions 8 and 9 of the questionnaire suggested that respondents felt very positively about the PBR process, finding the multi-agency approach particularly useful and the support offered by MBASS, STS and the EPS appropriate and empowering for schools, pupils and parents. A number of schools found the opportunity to meet different professionals and gain a different perspective regarding the issues very valuable.

However, there are a number of more negative or ambivalent comments about the PBR process. A recurring theme regarding the PBR meeting was that of time constraints. This was raised as an important concern. Many schools did not find the long wait between referrals and PBR meetings useful. Whilst a multi-agency approach is welcomed by schools, it can also lead to communicative breakdowns: several commented that they found it frustrating when more than one professional speaks at the same time at the PBR discussion, and that this can lead to confusion (when different professionals express different views).

Professional interviews

Semi-structured interviews were designed (see Appendix 3) and an email was sent to all PBR multi-agency team members to ask for their participation in the evaluation. Their experiences and their views are highlighted in Appendix 4. The author has chosen to provide some quotes in Table 5 to conceptualise what the author thought the professionals' views were.

Two professionals were interviewed for the purpose of the evaluation. Professional one was a specialist teacher for communication and interaction, and professional two was a social work manager, who was newly appointed to support the PBR process. Both professionals regularly participated in the PBR meetings and were working with children and families who had been referred to them through the PBR.

Table 5:

Professional one's views	*"I feel that the PBR is still in its infancy and with this in mind I am aware of the communication difficulties that we sometimes come across."* *"I find it very positive that someone from social services attends these meetings, often trying to make referrals to social services is very hard, and by the social work manager being available at the meetings I am able to ask her about children and families that need support and she is able to direct me to the appropriate services. Also when I am working with a child, I can also ask her to check if there is any involvement from social services."* *"I still find it difficult to understand fully the role of all the professionals that attend the meetings, It would be really good if we could shadow each other, so that we don't get confused about other professionals roles and professional remits. I often hear professionals say in the meetings "this is not my role"."* *"If feel that the role of health professionals is still unclear at these meetings. I think a CAHMS professional attended the first meeting in September, 2008. In terms of coordinating services this is still an agency we are finding difficult to co-ordinate with."*

Professional two's views	*"When I first began attending the meetings, I found it hard to get my head around what all the various professionals did. Coming from a social care background, my views inevitably link to the family as a whole. This often clashes with most of the referrers as they tend to be from the school."* *"I feel that I have learned a lot about the education system by being part of the PBR and this has helped me to gain a wider picture about the services available to children and families."* *"I feel that the process is working well and once people become more aware of PBR, the referrals will start to come in from wider services, I do still find it hard as a professional to understand some of the technical language."*

From both interviews a number of themes appear to emerge. These include difficulties in establishing roles and the possible gate-keeping of professional services, i.e. professional one's comment about professionals saying that some things are not within their role. This finding links with much of the findings stated in the research section of the report, such as the disadvantages pointed out by Wistow and Hardy (1991) and Petit (2003).

Another theme emerging was the usefulness of having various professionals, who are often difficult to access, being available at the meeting to provide their input and advice. This was also highlighted as a positive aspect from the perspectives of the schools that completed the questionnaire.

The scarcity of the health professionals being at the meeting was identified by the views above. This reflects the research regarding resources and overstretched services; health is a service that, with its own policy and agendas, may not see this meeting as a priority. This

supports the research by Watson (2006) regarding having a common goal and shared vision, which appears to be effective particularly for education and some social services, but health appears to still be clinically based and difficult to access. It would have been interesting to interview the CAMHS Tier 2 professional who is part of the PBR (although she has been unable to attend most meetings) to gain her views about the process. Due to her time constraints she was unavailable for the purpose of this evaluation. These views are not representative of all the PBR professionals and therefore cannot be used to generalise all professionals within the Dartford West Partnership.

Case study example

This next section focuses on an individual pupil who was discussed at the PBR meeting. The child was new to the area and was referred to the PBR by the school for concerns regarding his emotional development and violent outbursts (for the full referral see Appendix 5).

Tom Smith (all identities changed for the purpose of this report) is now aged 9 years 1 month and was assessed at 8 years 8 months.

Tom is in the care of the London Borough of Southwark. He has been in his current foster placement within Kent with Mr. and Mrs. Carr since 2008. His younger sister is also in the same foster placement.

Tom suffered significant trauma in his early years. He was first taken into care at the age of 3 years at the request of his mother who found it difficult to care for him and his sister. Both Tom and his sister were cared for by their maternal grandmother and step-grandfather. After returning to his mother for a short period of time, Tom and his sister were placed with foster carers once again. The current foster placement is the second placement to date.

Tom witnessed considerable domestic violence and has been subjected to physical violence too. He has been deeply affected by changes in primary carers and the instability this has caused. At present he does not have any contact with his parents as previous contacts have caused distress and anxiety for him.

Tom's educational school report highlighted that before being placed with foster carers in Kent, Tom attended a primary school in London. He began attending a Kent primary school on the 7th January (2008).

Since joining the primary school, Tom has displayed aggressive and defiant behaviour which has resulted in three fixed term exclusions. Tom was referred to the Partnership Based Review (PBR) by the school on the 11th December (2008) and this resulted in a number of professionals becoming involved. The PBR outcomes (see Appendix 5) highlighted that a multi-agency team would be appropriate and for this to be coordinated by the SEP.

In the school report, many strategies were highlighted as being implemented; for example, part time placement at a Pupil Referral Unit (2 days a week), support from the senior educational psychologist, anger management sessions, weekly play therapy sessions, social skills sessions, time out in the school nurture room and support for foster carers from Family Action. At the end of July 2009, Tom received an initial assessment with Child and Adolescent Mental Health Service (CAMHS) and was permanently excluded from the primary school. Tom received a place in another primary school in September 2009 (for a full history of MAT involvement see Appendix 6).

In the summer, a request for a Statutory Assessment was initiated and the TEP was involved in assessing Tom's needs for the Psychological Advice (see Appendix 7).

Outcomes for Tom Smith

For Tom the referral to PBR resulted in a lead professional coordinating the various professionals and agencies involved with him at this time. Particularly due to the fact that he was a child from a London borough, a high level of coordination was required to link with agencies out of the area. This was supported through regular MAT meetings which aimed to monitor and review his progress on a monthly basis. These meetings also provided the school with support, as it was clear from the referral and the information from the file that the school were finding it difficult to manage his challenging and unpredictable behaviour.

The part-time placement at the PRU was a result of the MAT meetings and therefore (at least temporarily) prevented Tom from being permanently excluded. A further outcome of the MAT was that Tom was offered a number of interventions. Unfortunately, these appeared to have a limited impact on the overall outcome for Tom (the permanent exclusion). None of the interventions were formally evaluated and, on reflection, the author feels that there may have been some overlap of services. For example, the social skills and anger management could have been included in one intervention rather than two single ones.

Another concern relating to the MAT process included the coordination of the different professionals. Through the analysis of the MAT it became clear that often the meetings were not attended by all professionals involved with Tom. For example, the social worker's role in

the TAC meetings was limited. This could be argued as a reflection of a wider social services organisational concern that does not necessary meet the objectives set by the policy relating to MATs (ECM, 2004). The limitations placed on the social worker included time and resources, as Southwark Social Services is understaffed with social workers having very high case loads.

On a positive note, the MAT meetings supported the foster carers by providing them a forum to discuss their concerns about Tom and access support services. However, a theme emerging from this case study was that a referral for emotional support from CAHMS took some time to develop (July, 2009). A health professional was not present at the MAT meetings, which in retrospect could have been beneficial for the school. Professional advice regarding the emotional complexities of a child like Tom could have helped the school to understand Tom's needs in more depth.

Positively for Tom, the MAT meetings and record of interventions and support provided to him helped professionals gain evidence and later gain a statement for his special educational needs under Section 323 of the Education Act, which ultimately will inform any school he attends of his needs and will ensure his progress will be reviewed annually, regardless of which authority he goes to.

Overall there appears to be some good practices seen through this MAT process, particularly regarding the sharing of information and professionals' agencies working together to review Tom's needs. However, there appears to have been some overlap in services and the lack of CAHMS involvement meant Tom's support for his emotional needs was lacking from outside agencies.

Discussion

The evaluation data identified a number of positives from the PBR process. The schools that responded to the survey found the PBR process useful to a certain point and found the different professional opinions valuable. The questionnaire sample was nearly 50% of the schools in Dartford West and schools that did not complete the questionnaire may not have been able to complete the evaluation as they may not have been involved with PBR to date. Also, changes in SENCos and the fact that the evaluations were sent to the Headteacher may have meant that information was not passed on.

Findings from the questionnaire add to the existing literature about working collaboratively and some of the ways this can be achieved; for example, the research put forward by Watson *et al.* (2006) and Sloper (2004). However, regarding Question 6, where schools were asked if the perceptions of the situation had changed after attending PBR, two people had disagreed with this comment. There could be many reasons for this; potentially some cases may not be resolved through the PBR process and may require further support. Or it could have been that the school staff member had not found the PBR consultation had changed their perception of the problem from pre-PBR. The evaluation could be developed further by interviewing parents and young people who have been involved in the PBR. This would add to the scarce research in this area.

The qualitative analysis also supports some of the literature which argues that at times protocols and procedures are not helpful (Hughes, 2006) for referrers who may feel that they often need a more immediate response from outside agencies.

The views from professionals sought for the PBR evaluation shows some similarities with the research on MATs discussed in the paper. Key issues remain, such as effective communication amongst professionals and the lack of support from Health and Social Services.

The case study anaylsis raised some questions regarding the effectiveness of the MAT process, as Tom was supported by many different agencies which created a possible overlap

in resources with the key resource of CAHMS remaining difficult to access, even through the MAT process. It is unclear whether the statement process for Tom can be linked to the MAT, as this was initiated at the time of his exclusion. However, the longer term outcomes for Tom linked to the ECM agenda (2004) are yet to be identified. It would be interesting to see in 10 years whether the outcomes for Tom have changed.

The evaluation itself was a small scale limited piece of work. The limited professional interviews meant that their information is difficult to generalise to the partnership. Also, the case of Tom is not generalisable as it was a single case study.

On personal reflection, the author notes a number of key issues relating to the PBR, which were not documented in the evaluation. Often issues of confidentiality were not addressed fully and, due to differing interpretations of what confidentiality meant, as a psychologist following the British Psychological Society code of ethics and the Health Professionals Counsel it meant that professional ethics were compromised. However, these issues over time appear to be less apparent as more effective collaborative practices develop. This links with the research stated by Hallam *et al.* (2004) regarding "teething problems" for newly established themes. A useful follow up could include follow up interviews a year on to see if these issues still remain. The author found communicating professional roles was the key to ensuring transparency during the PBR meetings. Often talking about any issues relating to ethics, professional roles and the sharing of information were highlighted as an agenda item at the end of the PBR. This was to manage any organisational and strategic issues that, if not addressed, could have found their way into the actual PBR meetings.

Conclusion

Overall there appears to be some supporting evidence, such as that provided by Hughes (2006), Watson (2006), and Atkinson *et al.* (2002), to highlight the positives of collaborative working. However, there appears to be no conceptualised model of what this means in practice. Instead, it appears that working collaboratively is an overall ethos rather than a function for any one professional. Many agencies are already working collaboratively through less formal means.

Some researchers, such as Beck and Young (2005, cited in Leadbetter, 2006), believe that the multi-agency agenda is a direct criticism on the professional, stating that the multi-agency agenda is a challenge to professional autonomy, and the status and economic position held by professionals. Moreover, it challenges the legitimacy of the claim that the professional has exclusive possession of specialised knowledge. Whatever the political agenda, the situation remains that professionals have to renegotiate their professional positions in relation to their client groups and to others in the new organisations within which they work.

In conclusion, the move to multi-agency working intuitively has numerous potential benefits. Many of these surround the problems associated with the fragmentation of services provided to children and families from education, health and social services. However, as multi-agency working is a concept rather than an identifiable structure, evaluations of its effectiveness are extremely difficult. When reviewing the evidence base for MATs working ten years ago, Glisson and Hemmelgarn (1998) wrote:

'While inter-organisational service coordination appears to be a logical and obvious way of addressing the multiple needs of those individuals most at risk, evaluations of service coordination efforts have been unsuccessful in documenting any major benefits…' (Hughes, 2006, p. 65).

This statement is still true. However, despite the scarcity of outcome data the status quo of fragmented services is not really an option given the imperative to develop more coordinated services made through both policy and research on children's and families' experiences of services (Sloper, 2004).

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APPENDICES

Appendix 1

Activity System

Appendix 2

Dartford West PBR questionnaire

Appendix 3

Semi-structured interview questions outline

Appendix 4

Interviews for professional views

Appendix 5

Case study referral to PBR

Appendix 6

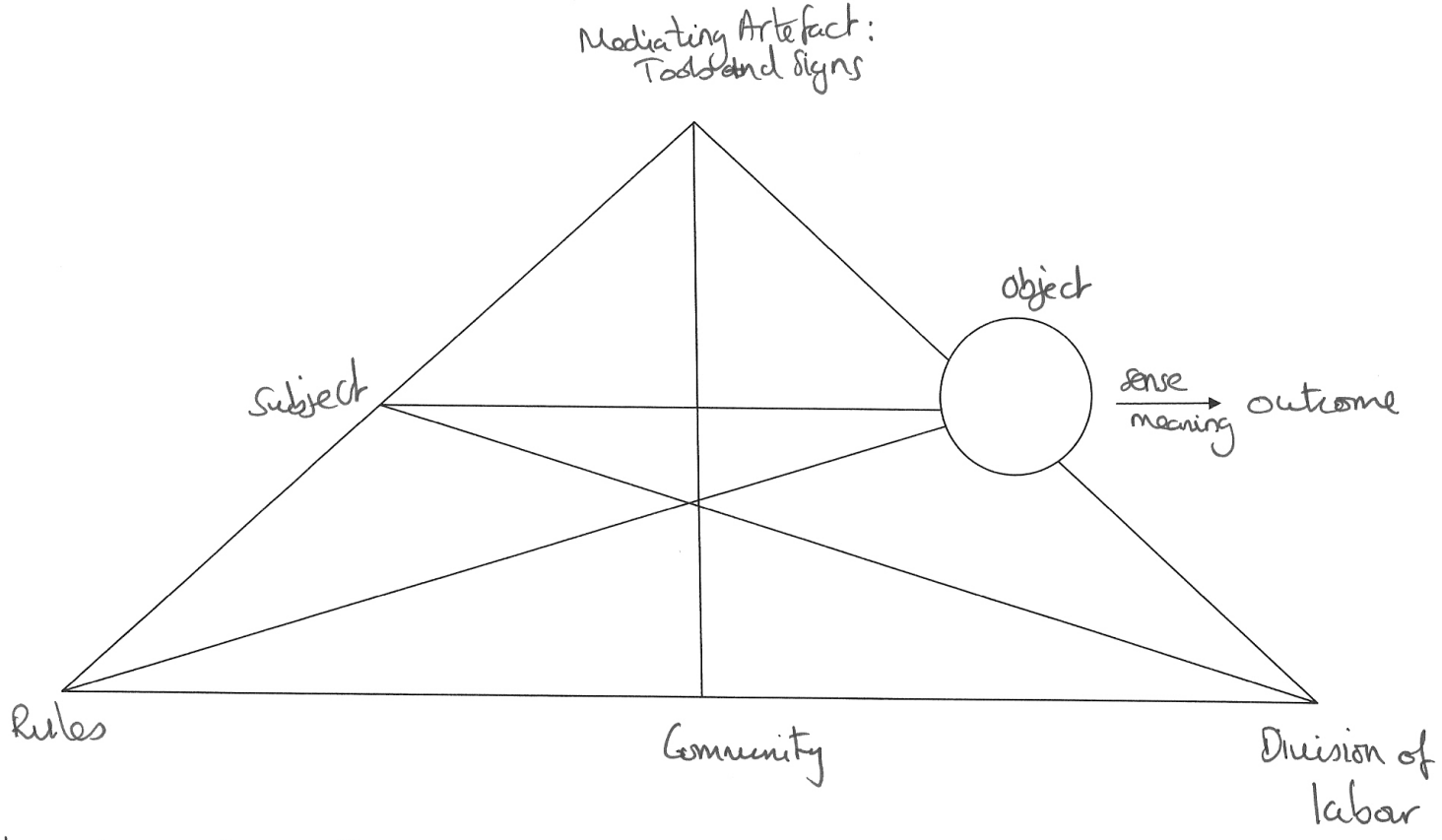
Multi-agency meeting minute for case study

Appendix 7

Psychological Advice for case study

Appendix 1

ACTIVITY SYSTEM



taken from Headbetter (2005) pg. 22.

Appendix 2

Children, Families, Health & Education

Kent County Council

[redacted] Partnership (PBR Review Questionnaire)

(Evaluation of consultation)

Feedback at the end of a sequence of consultation meetings with the [redacted] PBR team

To……School……..Date……

The Educational Psychology Service, working in Dartford West would like to evaluate the process of our multi sensory PBR team, as perceived by schools within the cluster. We seek the views of your school regarding the efficiency of the process (for the last academic year), and what we could do to make it more effective.

1. **The meetings *were helpful*, and afterwards I felt better regarding the issue.**

   Strongly disagree Disagree Agree Strongly agree

2. **I felt that the PBR team *listened,* and took my concerns seriously.**

   Strongly disagree Disagree Agree Strongly agree

3. **The meeting(s) helped me to be aware of what I had been doing well regarding the issue.**

   Strongly disagree Disagree Agree Strongly agree

4. **In the consultation we agreed a way forward, with some practical ideas about what to do.**

   Strongly disagree Disagree Agree Strongly agree

Appendix 3

Semi-Structured Interviews for professionals regarding the PBR process.

1) What are your views on the PBR process?

2) What are your views on the professionals working together to support the needs of children and young people in Dartford West?

3) What do you think could be done differently at PBR?

Appendix 4

Professional one's views:

Question 1

"I feel that the PBR is still in its infancy and with this in mind I am aware of the communication difficulties that we sometimes come across."

"I find it very positive that someone from social services attends these meetings, often trying to make referrals to social services is very hard, and by the social work manager being available at the meetings I am able to ask her about children and families that need support and she is able to direct me to the appropriate services. Also when I am working with a child, I can also ask her to check if there is any involvement from social services."

"I feel now that I have worked with social services and other professionals I have a greater understanding of the constraints professionals are under and generally a better understanding of their roles".

Question 2

"If feel that sharing information has helped a great deal"
"I feel it's more of a holistic approach to children and families"

Question 3

"I still find it difficult to understand fully the role of all the professionals that attend the meetings, It would be really good if we could shadow each other, so that we don't get confused about other professionals roles and professional remits. I often hear professionals say in the meetings "this is not my role."

"If feel that the role of Health professionals is still unclear at these meetings. I think a CAHMS professional attended the first meeting in September, 2008. In terms of co-ordinating services this is still an agency we are finding difficult to co-ordinate with."

"Confidentiality differs among professional and different agencies, particular Education versus social services and also Educational Psychology.

"It did feel a little deskilled when the PBR started it was scary to be seen as an expert on a panel when you also felt that this whole process was new to you".

"When I first began attending the meetings, I found it hard to get my head around what all the various professionals did. Coming from a social care background, my views inevitably link to the family as a whole. This often clashes with most of the referrers as they tend to be from the school."

"I feel that I have learned a lot about the education system by being part of the PBR and this has helped me to gain a wider picture about the services available to children and families."

"I feel that the process is working well and once people become more aware of PBR, the referrals will start to come in from wider services, I do still find it hard as a professional to understand some of the technical language."

Question 2

"I definitely think that all professionals are talking together is very helpful in identifying the most appropriate support for families and children."

"Also sign posted families and schools to the different services available, often you not quiet sure of what is out there and when you go to PBR other people can offer different services which are great. For example the voluntary agencies such as ARC".

Question 3

"Not so much differently, I think there are things that could be added to PBR, such as having a common language for all professionals. Because I am from Social services I often do not understand some of the education Jargon and this gets very confusing".

"Also I do sometimes feel that there can be some issues regarding how different professionals see the presenting concerns. I don't know how we can change what the priority concerns are for each professional as I think that our training and professional background means we will inevitably see the problem differently."

Appendix 5

Dartford [redacted]
(Local Children's Services Partnership Based Review)

Date of PBR: 11th December 2008
School Referring: [redacted]
Member of staff attending: [redacted]
Tel No: [redacted] e-mail address: [redacted]

Whole school issue
Group issue
Individual pupil issue

Inter–Agency Generic Referral Form for PBR services

This form is about - Child/Young Person Details:

orename:	[redacted]	Surname:	[redacted]	Sex: M / F	Date of Birth	Year group:
UPN:	[redacted]					

Address:	Number of Siblings	Position in Family
[redacted]	2	Eldest
	Ethnic Origin	Language
	White/Black Caribbean	English
Correspondence address if different:	Looked After Child	Looked after Child Authority – please specify
	Yes / No	Southwark
	Child in Need:	CP Register:
	Yes/No	Yes/No

Parent/Carer Details:
If the parent/carers live at more than one address, please complete a line for each address

ull Name	Address, post code, Tel (inc STD)	Relationship to child
[redacted]	As above [redacted]	[redacted]
Full Name	Address, post code, Tel (inc STD)	Relationship to child

School / Setting details:
If the child / young person attends more than one educational placement, please complete a line for each

School / Setting(s) name	Address, post code Tel (inc STD)	National Curriculum Year if applicable	Class / Group
[redacted]	[redacted]	[redacted]	[redacted]

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School / Setting(s) name	Address, post code Tel (inc STD)	National Curriculum Year if applicable	Class / Group

Level of SEN intervention

School action plus **Statutory assessment** **Statement**

Other Agencies' Involvement	Key Name	Role	Contact Details
a) Social Services	[redacted]	[redacted]	[redacted]
b) Education e.g. Portage, Specialist Teaching Service			
c) Health e.g. Child & Adolescent Mental Health Service, Speech & Language, Portage, School Nurse			
d) Other, e.g. Police, Youth Worker, Young Offenders Service, Voluntary Organisations			

Any other relevant information including current support available to the child/young person – e.g. language needs

[redacted] is currently in foster care with a supportive family, and has been with this family for a year. This is not the first foster family he has been with but most definitely will be the last as if this family cannot cope with him then he will, with his sister, have to be placed in a children's home. He was taken into foster care due to violence in the home. Natural mother and father are no longer together. He has sporadic contact with his natural parents. There has been a new baby sibling born but this child has also been taken into care.

[redacted] is a very bright boy but is angry all of the time and is prone to outbursts of anger/violence at any time. This violence can be directed to children, adults and surroundings. As a school, our concerns are for his safety but also for those around him. His latest outburst last week (Monday 24th November) resulted in a 48hr exclusion and we have requested further support from the social worker. He, and his sister, need specialist counselling and we need swift advice on how to deal with [redacted] There is also a real need for support for the foster parents at home as they have said that they are close to having to rethink the fostering of both of the children.

In the last week [redacted] has drawn a picture of himself and has written underneath it 'I want to kill myself' which he showed to class teacher but he then wanted destroyed.

Additional information: incidents on return from exclusion – ran away from school 2nd December, found 200m off school site, carers were informed and calmed him down, managing to return him to school by 2.00pm. Carers agreed to keep [redacted] home at lunchtimes as this seemed to be a difficult time for him. 3rd December [redacted] began to become angry again but managed to be removed to The Green Room (Nurture Room) before anything occurred. 4th December – another incident in which a yr 3 girl was kicked and a year 3 boy was chased into the toilets by a very angry [redacted] threatening to kill him. He was forcibly removed from this situation and taken home by carers for the rest of the day.

Name of GP [redacted]

Reasons for the Referral and indicate type of service requested

The reason for this referral is the escalation of violence displayed by [redacted] needs support. He is a very angry young man but cannot/will not articulate what or how the outbursts are caused. I would like either an assessment by an Educational Psychologist and/or behaviour/anger management help. We are also requesting support for the foster family at home.

Are there any identified needs or request s from the family regarding support needed at home?

Yes, help with coping with two very anger and often violent children.

Are there any issues regarding worker safety that should be taken into account in planning a service?

Possibly, as [redacted] can display violence towards anybody who challenges him, when he is in one of his tempers.

What strategies have already been tried and what were the outcomes?

There has been support from out FLO, he has time out when he feels he needs it, in the form of access to our Nurture Room and in class support.
Unfortunately due to the unpredictable nature of the outbursts we have been unable to see any beneficial effects from this apart from the fact that he looks forward to his sessions with the FLO and does make use of the room regularly, in order to calm down. Support from Time4U was offered but was put on hold by Social Services as it was felt that this would be too intense for the children, at that moment in time.

Date of the last meeting with parents/carers and agreed outcomes

27th November 2008 – agreed outcome was a referral to PBR, parents will also seek medical help through GP
nd request to Social Services for further support for the family.
There has been regular contact with the carers as each incident has occurred.

Schools view of pupil (for example strengths /weaknesses)

[redacted] can be caring towards other children and eager to help and support. He is an intelligent boy who is quick to grasp concepts/ideas. He can understand and read situations when he is calm enough to do so. Maths is particularly strong and enjoyed by him but he also excels in sport and science.
He is quick to loose temper and when in this mood he then can misread situations and struggles to control his emotions. He does not take criticism well and can be very negative. He is also impulsive, for example calling out in class.
[redacted] genuinely seems to be eager to learn and responds well to praise.

National curriculum levels /P scales/teacher assessment in core subjects

Key Stage 1:
Reading = 3C
Writing = 3C
Maths = 3C

Year 3:
Reading = 2A
Writing = 2A
Maths = 3B

October 2008 = Spelling Age 10yrs 8months

Current IEP targets:	Date to be reviewed
1) For [redacted] to be able to talk through his emotions and be able to control his temper buy removing himself from the trigger situation. 2) For [redacted] to work on the Year 4 objectives in Numeracy, where appropriate, e.g. investigations and extended work problems.	19th December 2008

What are your expectations regarding this referral?

Assessment by Educational Psychologist.
Support from a specialist in behaviour.
Support for the foster family at home.
As you can see we are in need of urgent help for this family and this child.

Name of Referrer (Person/Agency)	Date
[redacted]	01/12/08

Contact details of Referrer (address, telephone number, email address)

As above
[redacted]

Kent County Council is a data controller under the scope of the Data Protection Act 1998 and is therefore required to comply with the eight principles of good information handling. We will ensure that your information is processed fairly and lawfully and used only for the intended purpose(s). On occasion it may be necessary to share this information with other agencies on a need to know basis.

[redacted] 01[1].12.09 Meeting Notes.doc

TO BE COMPLETED AT PBR

PBR Discussion Notes (main points)
❖ Signed Parental Consent received ❖ LAC child ❖ Violent within school ❖ Comes form violent background ❖ Hit, punched & sworn at pupils and adults. Took 2 adults to restrain him ❖ Threatened to kill the pupil ❖ Carer has had to come into school to remove him ❖ [redacted] has been involved ❖ LAC Meeting on 16.12.08 – Chair should ensure needs are met ❖ John spoken to Centre Class re part placement in January ❖ School has spoken to Time4U counsellor ❖ Sporadic contact with Mum
Actions agreed at the PBR
➢ School to look to Time4You counselling and think about Therapeutic Play ➢ Senior EP to discuss issues at multi agency meeting ➢ Senior EP to co-ordinate support for Tyreece ➢ [redacted] to work with Senior EP
Timescale:
9th January 2009

Lead Professional Name:	Telephone Number:
[redacted]	

Type of support provided to school

Whole School Issues ☐ Group Issue ☐ Individual Pupil ☐

Communication & Interaction (C&I) ☐

Cognition & Learning (C& L) ☐

Behaviour, Emotional & Social Development (BESD) ☐

Social Care (MABSS) ☐

Physical & Sensory ☐

INSET ☐

Other ☐

Other – Please specify:

Part 1b - Parent/Carer and Child/Young Person Views and Consent Form

This form is for use when a child or young person is referred for a consultation and/or intervention on how best to meet his or her needs. When completed it should accompany part 1a and sent to the agency to whom the referral is being made.

- ***Section 1*** *should be completed by the referrer.*
- ***Section 2a*** *the referrer should ensure that the views of the parent/carer are recorded.*
- ***Section 2b*** *where it is appropriate to secure the views of the child or young person, these should be recorded here. Where possible, the parent/carer and child/young person should record their own views, otherwise the referrer or other professional can scribe for them.*
- ***Section 3*** *seeks the consent via signature of the parent/carer and child/young person to the sharing among agencies of relevant information held by each agency.*
- ***Section 4*** *should be completed by the referrer.*
- ***Section 5*** *is a separate medical consent form to be completed as appropriate to reassure the parent/ child/ young person that the medical details will be shared with appropriate agencies only separating out the general consent for data sharing from specific data on their medical history.*

Section1 Basic details

Childs name	[redacted]
Date of Birth:	01/02/00
Parent/Carer Name:	[redacted]

Section 2a Parent/Carer Views of current situation

What would you like to happen and who do you think could help with this?
[redacted] needs help in dealing with his anger. He is understandably angry at what happened to him when he was younger, but this anger is with him all the time. Anything can cause it to flare up, even trivial events. He has now been suspended from school twice and is in danger of being excluded permanently. He needs to put the past behind him and get on with what should be a very bright future.

Section 2b Child/Young Person Views of the current situation

What would you like to happen and who do you think could help with this?
Someone at the gym can help me deal with my anger.

Section 3 Parent/carer and child/young person consent to information sharing

- *Sometimes when you and your family have a problem you may need to speak with a lot of different people such as teachers, doctors, speech therapists, social workers etc. to get help. In order to help/ enable these professionals to work together to help you or your family, they often need to share information that each of them holds. This helps them to better understand your needs and organise their services to meet them.*

- *We would like, therefore, to have your consent to the agencies (usually Education, Health and Social Services) sharing the information held by them that may prove useful in helping to plan for meeting your or your family's needs.*

- *Obviously any personal information about you and your family will be discussed under strict rules, in line with the law, and will not be given to any other persons who are not involved in the process of planning to meet your and your family's needs.*

- *The Data Protection Act says that the processing of information should be fair and lawful, that it should be for a clear and specified purpose, that only relevant information should be disclosed, that it should be accurate, that it should be shared and held only for as long as necessary, that the rights of the data subject must be upheld, and that the system should be secure. The law also says we must share information in order to safeguard or protect a child or young person.*

I agree to information being shared and discussed to help me/my child and for the involvement of a Lead Professional assigned to support the referral made at Partnership Based Review (PBR). I understand that I will be consulted following these discussions regarding any future planning and actions.

Name of child/young person: [redacted]

Signature: [redacted] Date: 5-12-08

Name of principal/main carer: [redacted]

Signature: [redacted] Date: 4/12/08

SOCIAL WORKER

[redacted]

FOSTER CARER.

Section 4 Referrer Details

If consent has not been sought or the parent/carer and/or child/young person has not given consent, please say why.

If a child is at immediate risk of significant harm, the referral should not be delayed whilst awaiting parental consent if it is to the Social Services Department. In such circumstances, a telephone referral may be necessary and the form should be completed and submitted as soon as possible afterwards.

Name: ..... Title: .....

Service/Agency: .....

Signature: ..... Date: .....

Section 5 Medical Consent

Child's Name:	[redacted]
Date of Birth:	[redacted]
Parent/Carer Name:	[redacted]

I agree to medical information being shared and discussed between the appropriate agencies to help me/my child. I understand that I will be consulted following these discussions regarding any future planning and actions.

Name of child/young person: [redacted]

Signature: [redacted] Date: 5.12.08

Name of principal/main carer: [redacted] – SOCIAL WORKER

Signature: [redacted] Date: 4/12/08

TO BE COMPLETED AND E-MAILED TO:

[redacted]
FOSTER CARER.
[redacted]@kent.gov.uk

BEFORE 1PM - 7 DAYS BEFORE THE NEXT PBR

Appendix 6

Multi Agency Meeting
16th December 2008

Present:

[redacted] (Independent Reviewing Officer)..Chairing Meetion
[redacted] (Social Worker)
[redacted]s (Care Link)
[redacted] (Carelink)

Agenda

Briefly about children's behaviour at home and school
Ways we can support
Anne and Sussans role
Support
Respite

1.
[redacted] behaviour in school: May [redacted] lost his temper for the first time at school, verbally abusive, hurts adults when trying to move to a safe place – day after he heard about baby. PEP meeting things become worse since then. Barracked in toilets, pushed peers, grabbed by throat, restrained, head butted, [redacted] came and took [redacted] away. 2 day exclusion. Another occasion where he had lost his temper – ran around outside – took himself off the premises – [redacted] walked down to the main road. Third inciden – threatened a peer – threatening to kill – chased into the toilets – two teachers had to remove him from the toilet to release the child – 3 day exclusion. Very angry – looked at triggers. Looked at lunchtime and playtimes – showing less co-operation in class. At home largly okay at home – last PEP praising behaviour then problems at school – times when he has wound his sister up – usually exculates his sister;s behaviour – dis-respect to all females. We know because he is less active – less able to distract himself – behaviour marginally worse since contact with dad – same day as PEP meeting – next morning – not direct contact. PEP 11th November – saw phot from father which [redacted] had been asking for – remains defiant towards female at home – not all the time- may be defiant with [redacted] for a short time but corrects his behaviour. Move at home? [redacted] after meeting at school after exclusion – that evening he initially talked about killing himself – [redacted] reinforced why he shouldn't – [redacted] went out – [redacted] holding onto him to prevent him going into the kitchen and getting a knife

[redacted] – said can't just be put down to the contact issue – mum's birthday, seeing mum, [redacted] parents moving out, them moving out – problem anxiety built up from insecurity

[redacted]– feelings for mum very confused – he asks can you love somebody and hate somebody at the same time – he really hates mummy for what she did to me but I lov her as well.

[redacted]– Leah and [redacted] tend to fight with each other

[redacted]– Leah hasn't displayed anything – concerns for teacher who is pregnant

[redacted] does want to be held – even though he hits out – [redacted] will calm down more quickly.

[redacted]– known [redacted] for 3 years – 2 ½ yrs with last carer who had problems with anxiety – around feelings and behaviour. 4 ½ years chaotic parenting from birth family - at previous carers no care plan for him – court became involved another 9months – tried for adoption 10 people came forward but were not deemed suitable. Became unsettled about 4 mths into placement with [redacted] and [redacted]– [redacted] asked to see [redacted]– looking at what makes him erupt – when he is calm highly intelligent – emotionally literate – suggested to [redacted] that he needed help with these emotions – no apparent triggers but there are but we are often able to identify them because we are not sure – [redacted]s parents leaving will have triggered anxiety.

[redacted]– [redacted] and [redacted] written a card to mum.

[redacted] sees himself being punished – traits of anxiety of the unknown – How is his emotional well being being looked after?

[redacted]– Care Link

[redacted]– Clinical phycologist involvement? things too unstable to do anything at the moment – 'catch 22' situation

[redacted]– what would local CAMs offer?

[redacted]– look at overall pattern there has been massive progress – main issue around mum

[redacted]– difficulty for education he can't exhibit this behaviour – [redacted] in someway needs to see his mum because he would no he belonged –

[redacted]see mum in a controlled way

[redacted] we need to help [redacted] become emotionally stronger. Could get [redacted] to write or record a message about his feelings to his mum. See him up to weekly

[redacted] can see point of view for not seeing his mum – feeling that [redacted] needs to see mum How do we address his emotional stability.

[redacted]– clear message that he won't be seeing mum until at least the summer – summer school holidays – Spring Bank Holiday revisit timing – before he becomes agitated/ anxious about seeing mum.

[redacted] video the questions he wants to ask mum.

Local CAMHs long waiting list – 16 weeks plus.... – set in process, need to talk about placement

Education Plan:
PRU behaviour unit, gives respite within small PRU and school, high pupil/teacher ratio, and work on coping and social skills. [redacted] will also come into to support also.
KCC multi agency team referral – [redacted] is the lead professional with regard to [redacted].
Behaviour support – [redacted] suggested further assessment however [redacted] commented that he had assessments previously. [redacted] commented that the PRU might be the most appropriate. [redacted] made the point that currently the school is not in a situation to cope with [redacted] without additional intervention. [redacted] is concerned that an additional disruption will not be beneficial. [redacted] is concerned that working alongside children with behaviour difficulties might have a detrimental effect. [redacted] is concerned that [redacted] needs support in Anger management and self regulation.

[redacted] etc feel that the anxiety with regard to the PRU will be counter productive. This view was supported by the SS panel. [redacted] is concerned that there may be violence in the PRU which may be directed towards [redacted] and how this would affect him, there is a feeling that this may not be the way forward. There is a great deal of concern about [redacted]'s perception and his anxiety levels.
[redacted] is not well so the meeting at the PRU will be cancelled.
[redacted] was concerned that something must be in place for [redacted] in order that he is given help to understand and control his anger, which may have been exacerbated through recent disruptive circumstances but which is there continuously. We are just waiting for the next trigger and although there may be some way to predict triggers at home his anger is triggered instantaneously at school and he becomes out of control, a danger to himself, other children and adults. Therefore there must be either an increase, long-term, in in-school support or we access the PRU where [redacted] will have a much higher adult/student ratio and specialist support in behaviour management. In-school support would need to be someone with experience in EBD. [redacted] has managed to access a place at the PRU which is amazing given the demand on places. [redacted] has also agreed to be the lead professional for the Cluster Team in looking after [redacted] and [redacted]. It is important that [redacted] has appropriate counselling and/or therapy individually but he also needs some input with regard to social skills and behaviour within the school setting.

[redacted]
In school, no problems except [redacted] does not want to come into school and sometimes she will run off from [redacted] in the p/g however once in school she is fine.
[redacted] as home is busy and enjoys helping. The children have separate rooms and in the new house are on separate floors. Difficult few weeks some time ago at home. Took part in the school Christmas performance with confidence. [redacted] feels she carries around a 'twin sister' who represents her anger (badness) etc. [redacted] has been particulary supportive, [redacted] has low self-esteem this is continuous even when she is enjoying what is happening. [redacted] and [redacted] are very competitive with each other. [redacted] had difficulty separating from previous carers; both the children see the previous carers fairly regularly and this will continue.

Considering whether or not the children are best living together, long term [redacted] feels that they are better off together although feels that some separation might have been beneficial. Work to continue with the children on improving their relationship with each other.

Multi Agency Meeting
9th January 2009.

Present:

[redacted] - Practice Manager/Looked after children
[redacted] - Practice Manager
[redacted] - Head teacher
[redacted] - Educational Psychologist
[redacted] - Hartley SENCO
[redacted] - Care Link
[redacted] - Care Link
[redacted] - Social Worker
[redacted] - Independent Reviewing Officer (Southwark)

Overview of last meeting. No official minutes as yet.
Regular respite with Daisy, previous carer.
Adults make decision on contact.
Video contact ?
[redacted] - referral to CAMHS and video not appropriate at the moment)
Keep children together was agreed
Use of the PRU?

Agenda:
Update
Strategies for [redacted]/Education

1) Christmas - [redacted] relatively clam, received presents from real mum. [redacted] was unstable about this. This week [redacted] was very angry, felt that [redacted] gets all the attention and not fair. Whereas [redacted] feels that if [redacted] is angry it is her fault.

[redacted] last Thursday dinner time - threw dinner on floor, threw spoon at [redacted] She did calm down quickly and [redacted] talk to her, she could come up with words of apology but could not express what made her angry. Few days

later she then wanted her mummy but could not say why. She feels if one was bad then the other was good. [redacted] was bad on Wed then good Thursday and [redacted] was bad Friday, today, no wanting to come to school. [redacted] - [redacted] responds well to warnings. Talk to him, [redacted] feels that no-one in the house loves him but [redacted] reassured him that they all do.
Last night [redacted] wanted to leave home. Today [redacted] would not go into class, went onto field, [redacted] persuaded her to come in.
[redacted] said on Wednesday to [redacted] that when she is angry she thinks of Mummy and when she was angry Nanny would hit her.

[redacted] in school - home at lunch time and return for afternoon school. Two very good days, then an incident over a highlighter, he would not share use of it and when teacher sorted this he rammed tables into other children. However [redacted] did not admit this to [redacted] or [redacted]
Another incident - he kicked out at other children because they were looking at him. He needs somewhere to go where he is not looked at, screen/tent?
Teacher is very careful of groupings and there is an element of negotiation but this is not sustainable.

[redacted] competitive child, distressed child, very intelligent. Needs anger management, so can control this, can verbalise this. Contact with mum does seem to be a trigger. The fact that he is acting out is a sign that he is feeling more secure with carers and school. Made a request from service manager to support in class. Needs to know what is the day to day management of [redacted]. There is not a dedicated TA for him.

Statement - doesn't qualify for one - emotional needs a core problem - obviously not being met - social skills - [redacted] will be able to have someone come in once a week to work on Social Skills. [redacted] - we do have Centre Class - before go through statement we have to go through all the support mechanisms available - that includes Centre Class where he will have small group support with trained staff to deal with [redacted]'s emotional needs. PRU is a place for supporting - only for 1-2 terms. PRU and school work together.

They feel emotional needs are being meet but meet to certain degree. [redacted] – needs to self regulate himself within social situations.

PRU agree with school re-integration – VA liaison with TAs so we gain training and the link with

How would [redacted] feel at being two places in one week – how would he feel about being in a PRU.

He witnessed an autistic child at respite.

[redacted] – must understand PRU in this area. Differentiate approach in [redacted]s emotional support. He will get lots of things small groups.

Concerns of [redacted]'s' concerned about how [redacted] will see this – going away from school.

[redacted] – looking at a different type of intervention – reviewed every 6 weeks. Many different types of interventions – we have to be positive.

Unable to put [redacted] for a statement – education has to be positive.

Social Skills – specialist teacher, [redacted] will come in next Wednesday to observe [redacted]. (personal friend of [redacted]s') She needs to assess [redacted]. Then put strategies into place.

Her support will link into PRU – school/specialist teacher and PRU. They will sit down and work out the needs. PRU will do there own assessment and all areas will put together their assessment. Need to relate all groups together. [redacted] feels Southwark being negative.

LAC cannot compare to other children – people need to be aware that [redacted] might not manage.

20 hours was meant to be in place of PRU. – could be used to support in school and also act as money to support the liaison between the PRU spending some time over there.

Mindful of the fact that he is Looked After – needs to think about ensuring 2 people because of allegations. Believe PRU supply transport. Southwark have concerns but don't feel that there is any choice.

PRU two terms – [redacted] will be briefed.

Social Services need to be involved in the review meetings.

[redacted]'s wish to be present when [redacted] told.

[redacted] – positive is infrequency of behaviour difficulties – Care Link workers feel that emotional difficulties very deep. PRU – early intervention.

Adults from all agencies need to co-ordinate dates so work can be done with [redacted] before e.g. Mother's Day.

[redacted] mentioned meeting with mum while at PRU so they can help support this behaviour. Need to expose him to those external pressures.

PRU – Southwark will request that the 20hour funding could be available as well to support link with PRU and the 3 days in school. 20 hour funding initially to prevent PRU. [redacted] not 100% sure that there will be any cost implication to Southwark.

School applying for funding in Kent for children in Year 3.

Taxi to PRU – school needs to check that there will be a driver and an escort.

Meeting with [redacted] to discuss what is going to happen.

Frequent review meetings within Education. Review Meeting with all agencies Thurs 26th March finished at 2o'clock finish by 3.30pm.

School link with PRU – [redacted] and [redacted] to visit – to ask question.

No decision today on meeting with birth mother

Multi Agency Behaviour Support Service

Plan of Intervention

Child's Name:	[redacted]
Date of birth:	1/12/00
School Year:	3
School:	[redacted]
Parents Details:	Foster carers [redacted]
Initial assessment made by FWA on:	Family Action Dartford on: 19/1/09
Assessment made by Education on:	

Present at discussion:	
[redacted]	Social Services Dartford
[redacted]	FWA Acorn
[redacted]	Behaviour Specialist Teacher
[redacted]	FWA Dartford
[redacted]	Rowhill Outreach
[redacted]	Behaviour Specialist Teacher
[redacted]	School Nurse Team Leader

Outline of presenting Issues/ Progress

EDUCATION: [redacted] is currently in foster care with a supportive family and has been with this family for a year. This is not the first family he has been with but, most definitely, will be the last, as if this family cannot cope with him then he will, with his sister, have to be placed in a children's home. He was taken into foster care due to violence in the home. Natural mother and father are no longer together. He has sporadic contact with his natural parents. There has been a new baby sibling born but the child has also been taken into care.

[redacted] is a very bright boy but is angry all the time and is prone to outbursts of anger/violence at any time. This violence can be directed to children, adults and surroundings. As a school, our concerns are for his safety but also those around him. His latest outburst last week (Monday 24 November 2008) resulted in a 48 hour exclusion and we have required further support from the social worker. He and his sister need specialist counselling and we need swift advice on how to deal with [redacted] There is also a real need for support for the foster parents at home, as they have said that they are close to having to rethink the fostering of both of the children.

In the last week [redacted] has drawn a picture of himself and has written underneath it "I want to kill myself" which he showed to his class teacher but he then wanted it destroyed.
Additional information: incidents on return from exclusion – ran away from school 2 December, found 200 mm off school. Carers were informed and calmed him down, managing to return him to school by 2.00 pm. Carers agreed to keep [redacted] home at lunchtimes, as this seemed to be a difficult time for him. 3 December [redacted] began to become angry again but managed to be removed to the Green Room (Nurture Room) before anything occurred. 4 December – another incident in which a Y3 girl was kicked and a Y3 boy was chased into the toilets by a very angry [redacted] threatening to kill him; was forcibly removed from this situation and taken home by carers for the rest of the day.

SOCIAL CARE: [redacted] is presently living with his sister and two very supportive foster carers. There are also other teenage children in the family who are equally as supportive. His foster carers are finding it difficult to manage his challenging behaviour that also presents in the same way at school. As a result of his behaviour at school he is now attending Centre Class for two days per week. His foster carers would like support and advice on managing the high levels of aggression he shows. There are often triggers, for example, his lack of social awareness in certain situations. When asked to do something that does not give a choice, he can also become completely oppositional. His views on justice can also lead to an explosion of uncontrollable rage. He enjoys routine and does not welcome changes very easily. His foster parents believe that he is happy and enjoys a good relationship with his peers unless he becomes upset or agitated.

HEALTH:

ANY OTHER INFORMATION:

Agreed lead professional

[redacted]

Agreed Actions	Person Responsible	Timescale
Social Care: Family Action to support foster carers with new ideas and strategies on	MOC	

boundary setting and rewards. Family Action to liaise with other appropriate agencies that may be able to offer support eg Breakthrough. Family Action to set up school meeting with foster carers and other members of MABSS team, in order to implement complementary strategies. Family Action to attend relevant meetings where possible. Family Action to liaise with Social Worker to ensure all intervention is complimentary to existing support and care plans.		
School		

- *The MABSS aims to review this plan with the family and agencies involved after working with them for 6 sessions*
- *The service is offered for up to 12 sessions and FWA can support the*

[redacted]

20th April 2009.

[redacted]

[redacted] still has concerns at the level of violence that he still displays in school on the three days that he attends here. He needs supervision at playtimes and lunchtimes.
[redacted] – are the social services funding?
[redacted] – no
[redacted] – she has spoken to mum and a request from the SS to take to GP re: referral to CAMHS at Dartford. This presents a funding issue.
[redacted] – he will look into this.
[redacted] – gave feed back on the sessions that she has had with [redacted]. She feels that he has attachment issues. She feels that he needs more help, professionally.
[redacted] – he does not display the same issues at the PRU. He has more space there, there is more likelihood that if he hits out he will get hit in return. He has fun activities that will be taken away if he misbehaves.
[redacted] – carers are facing extreme behaviours and it is hard to put the strategies in place that she has advised. In discussion with carers, any places that are temporary he does not have issues, e.g. respite care and PRU. In places that he feels are permanent he feels he can express his anger. Fairness issues are extreme, he fights with sister.
[redacted] – feels that he has mood/conduct disorder. He uses previous experience to draw on to react to present situation and these are normally negative experiences. At the PRU he gets what he needs, more attention than [redacted] can give him. Anxiety is there, over mum.
[redacted] – he gets very angry/anxious even at the mention of Social Worker – [redacted]
[redacted] – he needs to learn to relate. Family therapy is what is needed here.
He will talk to parents regarding contact numbers for SS at Southwark.
[redacted] will talk to [redacted] LAC in Kent.
[redacted] to start the statement process.
[redacted] – [redacted] carer, is attending parenting courses.
Could you contact [redacted] – at CAHMS ?
[redacted] – to contact SS at Southwark to get all the current paper copied to school so that an Appendix B can be started.
[redacted] – what is setting things off at home?
[redacted] – boundaries put in place or fairness issues between siblings.

[redacted] joined the meeting and said that [redacted] told her that he will be attending the Pru for the next 2 Friday mornings.

[redacted] knows how to make a big impact both at home and at school.

[redacted] – will look at increasing hours at PRU.

[redacted] – carers will not be happy at this as they feel that [redacted]'s educational needs are not being met.

[redacted] – rather this than excluded, which is a real possibility if he continues behaving in this way.

[redacted] – Friday mornings, at the PRU, are more structured so he would be more challenged there. Hopefully the staff at the PRU will see what is causing the outbursts at [redacted]

[redacted] – friendship issues are there as well, he does know his behaviour upsets the children. He is no longer invited to tea with friends.

[redacted] – there are issues between [redacted] and [redacted] as [redacted] is invited to tea and [redacted] feels that this is unfair. Carers are trying to set up a reward scheme so that [redacted] can have a friend back for tea for an hour.

[redacted] – are the carers at crisis point?

[redacted] – yes, in the fact they are trying to find ways to deal with [redacted] but no they are not thinking of giving up on the children.

[redacted] – is Jan frightened of [redacted]?

[redacted] – to an extent, yes. [redacted] appears to react differently if it is just [redacted] there.

[redacted] – the issues here need to be addressed by CAMHS. [redacted] to write a letter asking for a referral for [redacted], collating all the reports that will be sent to school.

[redacted] – to contact [redacted] to confirm whether a referral has been forwarded to them about [redacted]. To complete Appendix B, emphasis on his behaviour, funding issues, emotional issues.

[redacted] – [redacted] is not coping with school 3 days a week so extension of the PRU to July would be beneficial as he could be looking at exclusion if he were to be at [redacted] School 5 days a week. He is already being excluded from classes when his behaviour does not allow classroom teaching.

[redacted] is creating issues as he has not mentally dealt with what has happened to him. This has not been dealt with in the past but it does need to be dealt with now, possibly psycho therapy/family therapy at CAMHS.

[redacted] does believe that his carers love him but he still has problems dealing with his past and although, as a school, we are putting measures in place to help him this has gone beyond what we can do for him and other professionals need to be involved.

[redacted] – how long can the carers foster the children?

[redacted] – they are in long term foster care, and no adoption is planned.

[redacted] – Southwark have said that if the statement is given then they would look into the funding for this.

[redacted] – need to emphasize that funding is beyond SA+ and [redacted] is taking funds from other children in the school.

All professionals will continue supporting [redacted] as already planned.

Next full meeting : 7th May 2009, 1.30pm

Multi Agency Meeting
7th May 2009.

Present:

[redacted] - Head teacher
[redacted] - Educational Psychologist
[redacted] - Hartley SENCO
[redacted] - MABSS
[redacted] - CLA Education Advisor
[redacted] - Class Teacher
[redacted] - FLO

[redacted] -

[redacted] - [redacted] has been great at home, situations where she wld blow up at home she has been able to control it. She has been working towards the incentive of golf clubs/bag and lessons. She accepts decisions better and she can recognise when [redacted] is trying to push her buttons.

[redacted] - sleep clinic has contacted and given advice as to getting her to sleep, leave her, not in [redacted] and not to be put to bed but let her fall asleep on her own. She falls asleep around 10 o/c and will not wake up again. However [redacted] feels that this is unfair.

[redacted] - he can see how [redacted] feels this is unfair and the lateness is not good for her.

[redacted], when he can reason then he understands that [redacted] does not need the amount of sleep that he does and that if he does not get the sleep he will be more liable to be angry.

[redacted] - why is [redacted] so restless at night.

[redacted] - anxious about being on her own, wound up from the day. This system is working at the moment but getting her up in the morning is harder. They will start to wake her earlier so that hopefully she will get tired earlier in the evening.

[redacted] - has been fine in school, the incentive of the golf is working. Only had one morning when she was concerned about coming in. Still worries, on occasion about, about changing for maths.

[redacted] - she is not confident about maths.

[redacted]- however, having sat with her in maths, she is not having problems in maths and this is getting better.
[redacted]- is her brother still a significant part of her thinking?
[redacted]- she will talk about her brother and this is in a positive way.
[redacted]- how is she managing conflict with him?
[redacted] - she tells him what to do!
[redacted]- played together for 20 minutes with no conflict which is a record. However [redacted] did then attempt a conflict, threaten violence. [redacted] then confided in [redacted] at a later stage, rather than it becoming a conflict then and there.
[redacted] - often end up separating them to do activities as this is safer, less likely to end in conflict. [redacted] is less able to settle to an activity that is [redacted]'s choice.
[redacted]- strategies that she has suggested does seem to be working at home for [redacted].
[redacted]- in school, they do worry about each other.
[redacted] - they also worry about the impact of the other's anger on adults. [redacted] seems to want to comfort the adult that is engaged with [redacted].
[redacted]- on the days that [redacted] at centre class, [redacted] is better in school.

[redacted]

[redacted]- more temper tantrums than anger or genuine emotion. Initially it was genuine anger and now it is a challenge to authority, avoidance to doing what he is told. He is worse on Thursday/Friday.

[redacted]- possibly [redacted] is deliberately seeking to disrupt school as he senses that he may be asked to leave so he is pushing it. [redacted] spoke to [redacted] about keeping his anger in at school as they really want to keep you here.

[redacted] he has been good today and she has told him to behave as she will not take him swimming or to the trip on Monday.

[redacted]- he is not trying with his work, he is having a tantrum. He responds better to men than women and [redacted] can talk him through a temper whereas [redacted] would end up being sworn at or physically attacked.

[redacted]- wants [redacted] from [redacted] visit the PRU so strategies can be the same. He has asked [redacted]s boss to set this up.

[redacted]- does get h/w from the PRU but he does do a lot of activities at the PRU, not class based.

[redacted]- she is concerned that at the PRU the activities are fun but at school he has to do class based work.

[redacted]- what is [redacted]s view of the PRU?

[redacted] - he knows he is there because of his behaviour.

[redacted] - but he knows school is about learning and yet at the PRU the focus is not learning.

[redacted]- yes but until [redacted] is in the place to learn emotionally then he will not be able to learn.

[redacted]- he is not blowing up at the PRU, he is able to keep it in.

[redacted]- depending on the environment he reacts. The PRU is a success in that he does not blow up there.

[redacted]- the PRU has failed as he is worse at school.

[redacted] - as he knows that the PRU is temporary so he is different to being here as he knows that is permanent.

[redacted]- if the anger is in the child then he will blow up anywhere whereas if the anger is trigger driven then the PRU environment is good for him as the triggers are not there.

[redacted]- how is he learning at school?

[redacted] - when challenged he is good but he rushes, work is sloppy, he does not like to be wrong and can blow up over this.

[redacted]- general behaviour is better, although he did threaten to stab JF two weeks ago. He is able to control himself to a degree.

[redacted] - biggest criticism is that PRU and school do not talk and as both institutions are involved in his education then they should be in constant contact.

[redacted] and head of PRU have been in contact with each other.

[redacted] - but there needs to be more regular contact.

[redacted] - he will look into this. He has asked [redacted] to visit PRU. (She has done this and feels that [redacted] was copying behaviour so was getting significant 1:1 time and under these circumstances he works well, if he has someone with him he can cope. He also needs space around him. He has been moved to the front of the class and this is annoying him as he cannot see what is going on around him.)

[redacted] - one of the teachers from the PRU will be observing [redacted] next week.

[redacted] - we also need to get CAMHS referral and social worker has not got back to [redacted] regarding how this is going.

Re-intergration?

Friday mornings - no longer to be attending the PRU.
[redacted] mentioned that [redacted] felt he was going to PRU on Friday as a punishment for mis-behaving on a Friday. He has been reassured this is not the case.
From June - for [redacted] to come back for another day, so he is in [redacted] Primary School for 4 days and PRU for 1 Then July he will be back in [redacted] Primary School for 5 days a week, depending on how it goes.

[redacted] feels that [redacted] should take some of the responsibility on his returning to school, he needs to show that he is ready to return to school.

PEP
[redacted] - would like [redacted] to be part of this meeting for a short time as he gets very anxious about meetings in school about him.
[redacted] - this can be arranged for a short period of the meeting.

[redacted] [redacted] is mis-behaving in class and other parents are concerned about his violence and do not want their child next to him.
[redacted] - this is also affecting his friendship in class, as he is not being invited to tea.

Funding -
[redacted] - Southwark will only agree to funding if needs can be proved as above that which can be covered by the funding already allocated to school from Kent.

[redacted] - if [redacted] is in danger, or other children then he would be excluded.

[redacted] - money would only be allocated once a statement has been granted.

[redacted] - how long do we have [redacted] for?

[redacted] - he will check on this.

[redacted]- would it be possible to have copy of notes o

[redacted]

[redacted]- he will check on this.

Meeting closed and the next meeting will be the

Multi Agency Meeting
18th June 2009.

Present:

[redacted] - Head teacher
[redacted] - Educational Psychologist
[redacted] SENCO
[redacted] - MABSS
[redacted] - CLA Education Advisor
[redacted] Centre Class (PRU)
[redacted] - Social Worker
[redacted] - Deputy Head
[redacted] Social Services Manager

Situation so far:

[redacted] - from 09/06/09 (Tuesday) [redacted] re-integrated to [redacted] School, however his behaviour at home had become unmanageable so he was removed from their care and placed in respite care. He is there presently.

[redacted] - visited [redacted] in respite and he seemed fine. He was told that he might be there indefinitely although the decision is now that he will be back with the [redacted] next week.

[redacted] - [redacted] has not been able to be back into the classroom, he has needed 1:1 support to stop any possible disruption. He has been with various TA's or staff and kept in the Green Room.

[redacted] behaviour is based on the fact that his safety net has been removed. The whole situation is in danger of breaking down, school, placements and himself. Something needs to be done.

[redacted] - he has threatened to kill himself, he was standing on a wall in the playground, saying that he wanted to die and he would jump off.

[redacted] - he was very emotional and wanted to write a letter to real mum. In it he stated that he is very angry with her, why did she hit him. He is getting into trouble at home and school because of it, he is on a thin wire and is unhappy.

[redacted] - where are we in terms of paediatrician?

[redacted] - awaiting appt.

CAMHS referral. He is not ADHD or ASD.

[redacted]- we do not know that.

[redacted]- We do as he has been assessed, the issues are based on his emotional needs.

[redacted]- he would not need CAMHS if he did not have some psychotic problems.

[redacted]- he was assessed by Care Link and he was not seen as diagnosed with his.

[redacted] advisor for Kent has said that Southwark CAHMS should not have been withdrawn until local CAMHS was in place.

[redacted]- there are always problems when linking with local agencies.

[redacted] he has been referred via GP but he is still on waiting list for CAHMS to be assessed. [redacted] has asked for a pill to make him less angry. Have received a letter from CAMHS, asking if an emergency appt becomes available would they be able to take it. Yes they would. However the secretary at CAMHS was not certain where this letter came from.

[redacted] - he needs to be seen by paediatrician for this to be organised.

[redacted]- where are we on the statement?

[redacted]- has been applied for, will be discussed on 20th July and if it is to go to panel then a decision will be made by 15th October 2009.

[redacted]- is this behaviour or learning?

[redacted] - behaviour.

[redacted] without him going to the PRU he would have been excluded many times

[redacted] - it would as Southwark would maintain the statement and any money would come straight to the school.

[redacted] - in the meantime he needs support/assessment to help him remain in mainstream education.

[redacted] - how do we do this?

[redacted] - GP

[redacted] - I have taken him twice and nothing has been done as yet.

[redacted] - he needs to see GP and be seen asap

MO'C - it is 12 week wait.

[redacted] - if need be I will call the paediatrician.

[redacted] joined the meeting and gave her review of [redacted]:

High level attention seeking, bad language, violent, defiant. His emotions are so sever that he can swing from very good to very bad. There is no control once he is in an angry mood.

[redacted] - has he been able to remove himself form any situations? He has told [redacted] that he has twice.

[redacted] yes, once, last Thursday on the playground.

[redacted] - is he ever going to see his Mum?

[redacted] - it was planned for the summer however not sure now, in this situation. He witnessed domestic violence, he suffered emotional and physical abuse from his mum. He has had a letter from mum.

[redacted] - he would not read it, he said he hates mum.
[redacted] - he has said that he misses [redacted] and [redacted]

[redacted] - [redacted] has been told that he has got to control the anger.

[redacted] - he cannot control it as he gets angry. When he did walk away [redacted] asked [redacted] a cuddle would help and he ran to her for a cuddle.

[redacted]- does look on [redacted] and [redacted] as parental figures and he is terrified by his behaviour and that he is going to loose his placement.

[redacted]- what are we going to do until a statement is given?

[redacted]- needs an expert assessment.

ACTION:

School and Social Services to write to GP, regarding behaviour that is unacceptable. ([redacted]) Social services give school permission to write to the GP.

[redacted]- if this will not result in an assessment then let him know so that he can contact them himself.

[redacted]- LAC funding from Southwark may give school some funding for 1:1 support to the end of term.

[redacted]- part of the reason he can control it that there is no competition at the PRU, whereas at Hartley Primary School he is faced with competition.

[redacted]- he is competitive, the other children are aware that if they give him a false sense of security they do not have to face his anger.

[redacted]- he has also stated that he has more space at the PRU, he is not confined so much at the PRU.

[redacted]- he needs to be the best at everything.

[redacted]- he feels that he has failed with his own mother, so he feels that he must be the best at everything so that he does not fail again.

[redacted]- he has been told that his mother did want him, and did fight for him in court but she could not get him due to how she behaved towards him and his sister.

[redacted]- [redacted] needs closure on the issue of his mum and the assessments might begin to give him this.

[redacted]- [redacted] needs to reassure him that he will come back but that his behaviour has to change.

[redacted]- she has done this.

[redacted]- Social services do acknowledge that [redacted] is difficult to care for and that respite might have to be planned into the future for time for [redacted] and [redacted] to have time for themselves.

[redacted]- the current respite care is happy to have him.

[redacted] he has been hungry for 2 mornings and quite tired.

[redacted]- not saying there has been a disregard of duty of care. [redacted] is quite exhausted and maybe too emotionally upset to eat or sleep.

[redacted]- it is a break in routine that does not help and then when he returns they have to pick up the pieces.

[redacted]- any outward bound activities?

[redacted]- he goes to football, however he has been given his third and final warning.

[redacted]- children from [redacted] go to Treejumpers.

[redacted]- he has been there.

[redacted]- respite will not mean he will change his behaviour as he cannot do this on his own, he needs help to do this.

ACTION:

[redacted]s - *will be contacted to see if she can come in to support [redacted]. He will not be in class, as he cannot cope in the classroom situation and he will be in the Nurture room, with 1:1 support. This is not meeting his learning needs but it is what needs to be done in order to keep him in school.*
[redacted]- *will let school know if the funding is available.*

[redacted] - he may have similar symptoms to ADHD but he is anxiety driven and there could be medication he could take for this but he needs to be assessed quickly.

[redacted] has seen a paediatrician ([redacted], consultant paediatrician for LAC in Southwark) and said it was not ADHD but was emotional difficulties.

[redacted] - however the paediatrician did not ask for a report from school.

[redacted] - this is very unusual as paediatricians normally contact the school for a report.

ACTION:

[redacted] *to remain in PRU on a Wednesday in the next academic year for the foreseeable future.*

[redacted] *to move back with the [redacted]'s 27th June 2009.*

Next meeting: 21st September 2009, 2pm.

Appendix 7

STRICTLY CONFIDENTIAL

APPENDIX D/F (School Age)

PSYCHOLOGICAL ADVICE

EDUCATION DEPARTMENT – KCC
Advice On A Child Who May Have Special Educational Needs

Please note that all of the information on this form will be copied to parents and all agencies directly involved with the child.

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1. CHILD'S PERSONAL DETAILS **SPN Reference:**

Surname: [redacted] **Forename:** [redacted]

Address: [redacted] **Date of Birth:** 02.12.2000

Postcode:

School: [redacted]

Sex: Male

Religion: Not known

Home Language: Not known

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2. PERSON(S) WITH PARENTAL RESPONSIBILITY

Name(s): [redacted]

Relation: [redacted]

Address: [redacted]

Postcode: As above

Home Telephone: [redacted] **Day Telephone:**

3. BACKGROUND

Referral Background

[redacted]'s Special Educational Needs are being assessed under section 323 of the 1996 Education Act and this report constitutes the psychological advice.

[redacted] is in care of the London Borough of Southwark. He has been in his current foster placement within Kent with [redacted] and [redacted] since 2008. His younger sister is also in the same foster placement.

[redacted] has suffered significant trauma in his early years. He was first taken into care at the age of 3 years at the request of his mother who found it difficult to care for him and his sister. Both [redacted] and his sister were cared for by their maternal grandmother and step-grandfather. After returning to his mother for a short period of time, [redacted] and his sister were placed with foster carers once again. The current foster placement is the second placement to date.

[redacted] has witnessed considerable domestic violence and has also been subjected to physical violence. [redacted] has been deeply affected by changes in primary carers and instability this has caused. At present he does not have any contact with his parents as previous contacts have caused distress and anxiety for him.

[redacted]'s educational report highlights that before being placed with foster carers in Kent, [redacted] attended [redacted] Primary School in East Dulwich, London. He began attending [redacted] School in Kent on the 7th January 2008.

Since joining [redacted] School, [redacted] has displayed aggressive and defiant behaviour which has resulted in three fixed term exclusions. [redacted] was referred to the Partnership Based Review (PBR) by the school on the on the 11th December 2008 and this resulted in a number of professionals becoming involved. In the school report, submitted in support of the statutory assessment process, it is identified that many strategies have been implemented. For example, part time placement at the Centre Class Pupil Referral Unit (2 days a week). Support from Senior Educational Psychologist ([redacted]), anger management sessions, weekly play therapy sessions, social skills sessions, time out in the school nurture room, and support for foster carers from Family Action. At the end of July 2009 [redacted] received an initial assessment with Child and Adolescent Mental Health Service (CAMHS) and will be on roll at [redacted] School in September 2009.

Previous Psychological Interventions or Assessments

[redacted] (Senior Educational Psychologist) has been supporting [redacted] and has attending many multi-agency meetings regarding [redacted]'s behaviour; social and emotional difficulties (see consultation record dated 23.01.2009). I have referred to this report at times throughout this assessment.

Other Professional Involvement

[redacted]

Social Worker, Southwark
Family Action, Dartford
Rowhill Outreach Service
Kent Safe Schools

Basis of Assessment

I met with [redacted] and [redacted] (Foster Carer) at Joynes House on the 7th August 2009. On this occasion a meeting with [redacted]s class teacher was not possible due to the school holidays.

This advice is based on:

- Meeting with [redacted] and the administration of the WIAT II Word Reading, Spelling and Mathematical Reasoning subtest, 1 scale from the Beck Youth Inventory (Self-Concept) and the Myself as a Learner Scale.
- Conversation with [redacted] on the telephone on the 7th August 2009
- Information provided as part of the statutory assessment process.

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4. VIEWS OF CHILD AND PARENT

[redacted] views

When I first met [redacted] he appeared to show a little apprehension when I spoke with him. However, after a short time he appeared to engage in conversation more openly. I spoke with [redacted] about his likes and dislikes especially regarding school. He stated that subjects he liked the most included sports; he told me that he is on the gifted and talented register for being good at football. He added that he also likes computers and is good at spelling, writing, and making friends. When discussing his dislikes [redacted] stated that he did not like school work and did not think he was good at [redacted] school or at home.

Views of [redacted]

[redacted] reported that [redacted] behaviour has improved from when he first arrived in the placement. However, he can still demonstrate some moments of unpredictable outburst. She added that this generally tends to be associated with situations were [redacted] does not want to do something or comply with rules.

She told me that she was positive about [redacted]'s start in [redacted] Primary and added "we hope this is a fresh start for him." She continued to state that, in her opinion, [redacted] will require one-to-one support in both academic work and building positive peer relationships. She stated that [redacted] quires a lot encouragement and support to complete homework tasks and to follow instructions. She also stated that [redacted] found it difficult to fully understand instructions as he had a tendency to only listen to parts of the instructions or he can often misinterpret conversations which lead to him becoming angry.

[redacted] described [redacted] as impulsive and stated that he finds it difficult to process information. He will react without listening and has difficulty in processing social situations. She added that this often cause disagreements in social situations such as play time or in the cloak room. She advised that [redacted] feels personally attacked by peers and adults and therefore always responds to conversations in a negative manner even to positive praise.

[redacted] also told me that [redacted] can show empathy when he sees someone crying, "he always feels bad for them." She also stated that he can be very thoughtful too. For example, he recently picked out a present for his previous foster carer so that he could give this to her when he next saw her. This was a spontaneous gesture that [redacted] carried out without any direction from [redacted]

5. CURRENT SITUATION (Description of Child or Young Person)

- **Physical Development**

[redacted] is reported to be in good health. He is of slim build and very active. He enjoys sports, in particular football, and is involved in a football team outside of school. At home [redacted] enjoys activities such as computer games and going out with his foster carers.

- **Approaches and Attitudes to Learning**

The school report that [redacted] is an intelligent boy who has an interest in general knowledge. He has particular strengths in numeracy and enjoys being challenged with mathematical problems and is on the gifted and talented register for his numeracy skills. However, [redacted] does not like to get things wrong. The school reports that he can sometimes become frustrated if he perceives himself to be getting his work wrong or if he feels he is not the best (when compared to his peers) at any given activity.

During my one to-one meeting with [redacted], he did display some initial reluctance to conduct some mathematical equations, but with encouragement [redacted] participated in the activity. I observed [redacted] to show motivation to continue with the task when he could see that he was getting the answers right.

During the one-to-one session [redacted] found it difficult to remain focused and complained when he was asked to complete the Myself as a Learner questionnaire. He stated that he did not enjoy filling out forms and was tired of talking to different professionals. Even after being encouraged by myself and [redacted] refused to comply with the request. At this point [redacted] asked if he could take a break for a while, we had been working for 20 minutes by this time.

After his break [redacted] was asked if he would like to do some spellings and on this occasion he did comply with the request. This is consistent with what has been reported by the school, who have stated that [redacted]s willingness to comply with learning tasks depend highly on his motivation and general mood.

[redacted] report highlighted that [redacted] able to adapt to a structured routine as identified by the Pupil Referral Unit which stated that [redacted] was working well in the unit. [redacted] confirmed this and stated that [redacted] thought the work at Centre Class was easy and did not challenge him.

- **Speech and Communication Skills**

[redacted] was able to express himself quite adequately to an adult he does not know well. During our one-to-one meeting he responded appropriately to direct questions, and his speech was generally clear and intelligible.

The school reports that [redacted] can often misinterpret communication from peers and adults and as a result he can become aggressive and violent.

- **Educational Attainments**

[redacted]'s Key Stage 1 results are reported as being:

Reading	Level 3c
Writing	Level 2a
Maths	Level 3c

[redacted]s current Key Stage 2 results are reported as being:

Reading	Level 3c
Writing	Level 3b
Maths	Level 4c

This highlights that [redacted] is making progress in Mathematics and Writing, both subjects which he had highlighted as being two of his least favourite lessons in school.

[redacted]s skills in mathematics, spelling, and word reading abilities were tested using the Wechsler Individual Achievement Test (WIAT II). He enjoyed this aspect of the one-to-one session; because of his competitive nature [redacted] enjoyed the challenge of getting a really high score. However by the administration of the third test, his concentration was beginning to fade and he tried on many occasions to change the topic of the conversation.

WIAT II	**Standard Score**	**Percentile Rank**
Word Reading	106	66
Numerical Operations	121	92
Spelling	110	75

Centile scores of between 16 and 84 are within the broad average range for the child's age group. A centile score of 1 is exceptionally low, meaning that 99 children out of a hundred of the same age would achieve a higher score. A centile score of 99 is very high, indicating only 1 child out of a hundred would get a higher score.

[redacted]'s achieved a score within the high end of the average range for the subtest Spelling and Word Reading. His score for Numerical Operations was above the average range, confirming that numeracy is strength for him.

- **Behaviour, Emotional and Social Development**

[redacted]'s behaviour is described by the school as being extremely challenging. He will occasionally be abusive to teachers and peers, and will often be non-compliant and extremely demanding of attention. He has had three fixed term exclusions for serious violent incidents involving other pupils or members of staff. At home, [redacted] describes that she is concerned about [redacted]'s social skills and difficulties in recognising his angry outburst, she described that sometimes he can "lash out" and that he is unpredictable.

[redacted] stated that [redacted] can be caring towards others and eager to help and support. The school reports that [redacted] welcomes opportunities to be given responsibilities in the classroom. However, due to his impulsive nature and difficulties in managing his emotions he often loses these opportunities.

[redacted] stated that [redacted] becomes highly distressed when he is confronted about his behaviour. During my one-to-one meeting with [redacted] I asked him to complete a questionnaire called "what makes me angry?" an information gathering tool which attempts to identify situations that may trigger an angry response by a pupil. This was to help identify

situations that may trigger angry outburst from him. [redacted] become frustrated and stated "I know I get angry" "I don't want to talk about it." [redacted] only agreed to complete the questionnaire when he was seated away from myself and [redacted] so we were unable to view his answers.

Below are a few statements that [redacted] highlighted as situations that made him angry.

- When I am shouted at
- When people stop me doing what I want to do
- When I have to do something I don't want to do

[redacted]'s answers to the statements suggested that negative statements, comments or actions towards him, in particular actions of others which are out of his control or when he does not get his way are often the triggers for his anger. This is consistent with the information provided by the school and [redacted] regarding [redacted]'s behaviour.

The school reports that although [redacted] initially made many friends at [redacted] many children are now wary of [redacted] due to his outbursts. They added that [redacted] has a limited circle of friends and can cause conflict at play time if games do not go his way. Mrs [redacted] reported that [redacted] has difficulties in understanding social situations and engaging positively in social interactions.

[redacted] completed the Beck Youth Inventories, a five scale report measure that can be used separately or in any combination to asses a child's experience of depression, anxiety, anger, disruptive behaviour and self-concept. This involved [redacted] responding to a series of statements read aloud to him and then indicated whether each statement was 'never', 'sometimes', 'often', or 'always' true. (In general the average T-score is considered 40 – 60 with 50 as the mid average.)

Inventory	**T-Score**	**Beck Descriptor**
Self-Concept	31	Much lower then average

Other inventories were not completed due to [redacted]'s non-compliance with the remainder of the assessment.

On the self-concept scale [redacted]e circled 17 out of a possible 20 statements as either 'never' or "sometimes." These included:

- I like myself
- I like my body
- I am happy to be me
-

[redacted]'s responses indicate that he has low self-concept about his appearance and capabilities. However, self administered tests should be taken with caution as this may not be an accurate measure of [redacted]'s true feelings about his self-concept.

- **Independence and Self-help Skills**

Although [redacted] struggles to self regulate his behaviour on most occasions, the school report states that sometimes [redacted] is able to remove himself from situations if he sees that he is getting angry.

[redacted] requires support from a teacher or Teaching Assistant (TA) through most tasks....

6. SPECIAL EDUCATIONAL NEEDS

Area's of strength

[redacted] attends school regularly and has built some positive relationships with adults, such as the TA who describes him as caring and intelligent. He enjoys PE and is placed on the gifted and talented register for his skills in football and numeracy. With areas that capture his interests (e.g. football) he can be more focused and engaged in the learning task. [redacted]'s ability lies within the average range and he appears to be making academic progress in school.

Area's of difficultly

[redacted] presents with social, emotional, and behavioural difficulties and has suffered significant trauma in the past. He has had to endure many changes in a short period of time and this has resulted in unstable relationships with the primary carer. He finds it difficult to regulate his own behaviour or to reflect on the consequences of them. [redacted] has very low self worth and this means that he not only has a negative view of himself, he also perceives others view him in this way too. He lacks social skills, particularly how to manage wining and losing in games. [redacted] also struggles to manage his anger and frustration in an appropriate manner.

7. AIMS

1. **To develop his social and emotional literacy and understanding**
2. **To develop his ability to regulate his own behaviour**
3. **To reduce his anxiety and develop a more positive view of himself**
4. **To improve his social skills and interactions with others**
5. **To be able to deal with anger and frustration in a more acceptable manner.**

8. EDUCATIONAL FACILITIES AND RESOURCES

General

[redacted] **needs:**

- Access to a broad and balanced curriculum which are suitably differentiated and modified to take account of his specific areas of difficulty.

- He requires a supportive and sympathetic environment where all staff are aware of his difficulties and adopt a consistent approach.

- A co-ordinated multi-agency approach, especially with social services and CAMHS, which supports interventions to deal with school and home issues and promotes positive links between the two.

- Access to additional support to enable him to work one to one or in a small group for specific activities.

- Instructions to be clear, concise, literal, and unambiguous with assignments being given in manageable chunks with clear expectations and outcomes.

To develop his social and emotional literacy and understanding

- Access to therapeutic interventions to help him work through his past experiences.
- A program on emotional literacy delivered in a small group using materials such as circle time, role play, and therapeutic stories. The use of the primary SEAL program may be beneficial.
- Approaches to develop his problem solving skills.
- Opportunities to take responsibility for himself and/or others for specific tasks.

To develop his ability to consistently regulate his behaviour and recognise the consequences of his actions

- Follow a programme to specifically teach [redacted] about thoughts and feelings of himself and others (emotional literacy).
- Use of books, TV programmes, everyday examples to outline the connection between thinking, feeling and behaviour.
- Discuss role-play and different perspectives of an event.
- As far as possible ensure [redacted] has to experience the consequences of his actions, e.g. clearing up something he has broken.
- Always explain in clear, precise, straightforward language the course of action following an incident.
- Opportunities to develop his own problem solving skills, e.g. identifying triggers and alternate ways of behaving
- Consider a self-monitoring sheet for [redacted], e.g. each lesson he rates himself on particular targets e.g. not shouting out, or completing a set task.

To reduce his anxiety and develop a more positive view of himself

- Opportunities, as appropriate, to explore, off-load, and to work through his feelings. This could be done through the use of therapeutic stories, or space and time to talk and reflect whilst doing creative activities.
- Close liaison with Child and Adolescent Mental Health Service (CAMHS).
- Opportunities to use his strengths e.g. sports and mathematics.
- Provide opportunities to increase confidence, for example give responsibilities within the classroom.

- Frequent opportunities to experience success and to be given positive feedback for what he does well within school. This could be supported by a clearly arranged system of praise and reward in the form of charts, house points or as appropriate.

- Involvement in the planning of his targets so they are meaningful to him.

To improve his social skills and interaction with others

- Follow a social skills programme to specifically teach [redacted] about developing and maintaining friendships. Skills such as sharing, turn-taking and listening could be explored.

- Small group work to help develop social skills and awareness of appropriate behaviour through activities such as circle time.

- Planning for some unstructured times of the day by organising social activities which promote positive interactional skills.

- Use of social stories to teach social skills by providing social cues and responses.

To be able to deal with anger and frustration in a more acceptable manner.

- Use to be made of a behaviour management programme aimed at avoiding conflict and developing self-control.

- Access to a sanctuary/haven area for calming down or pastoral support.

- In class, clear structure and routines, with early warnings of change etc so as to reduce anxiety or frustration.

- A quiet, calm approach to be used, with provision for [redacted]'s feelings to be acknowledged i.e. "I understand that you are upset/angry however....."

- Remind [redacted] how he may have successfully dealt with similar situations before.

Home/School Liaison

Regular contact should be maintained between home and school. Parents/Guardians should be involved in target setting and review of targets.

Review and Monitoring Requirements

[redacted]'s progress will need to be regularly reviewed by the school, [redacted] his foster carers and all professional agencies's involved to ensure the interventions and strategies in place are effective.

PROFESSIONAL PRACTICE REPORT FOUR

Working with New Arrival families using a Community Psychology approach

Abstract

PROFESSIONAL PRACTICE REPORT FOUR

Working with New Arrival families using a Community Psychology approach

Abstract

This paper discusses the work of the Educational Psychology Service (EPS) within a South Eastern County and the role it has in gaining the views of Slovakian families who have recently arrived into the area. Discussions within the locality team highlighted a gap in the services being provided to this community. Although a number of Slovakian young people was attending the local schools, many had problems with persistent truancy. Various professionals such as the Education Welfare Service (EWS), Family Action and Specialist Teachers had reported difficulties in engaging effectively with families, thus making their work with these individual young people particularly challenging.

In collaboration with the EPS, these different support services conducted a needs analysis to understand the community, with the aim of understanding the experiences and the views of patents and pupils from the Slovakian community who were identified as newly arrived. The project was called the E2L project and consisted of Education Welfare Services (EWS), EPS Family Action (FA) and the Ethnic Minority Achievement Service (EMAS) which in turn consisted of three specialist teachers, one of whom was from Slovakia.

The Trainee Educational Psychologist set out to gather data from the perspective of the parents of the young people who were experiencing difficulties in schools. Overall the results identified some good practice amongst key professionals but the results also suggested difficulties young people and their families were having in feeling included and settled in their current school environment.

Introduction

Introduction

This paper seeks to explore the views of Slovakian families regarding their experiences of education, professional support and access to services since their arrival in the UK. The rationale for this includes the direct relevance to the local context and professional work of the Trainee Educational Psychologist and the Educational Psychology Service, particularly with regard to supporting and providing access to hard to reach communities such as the Slovakian new arrivals. Within the last five years the local area has seen an increase in Slovakian new arrival families. As the school is often the first place that sees a change in its demography, two local secondary schools began to identify the need for Local Authority support to understand and engage with the Newly Arrived Slovakian children in their schools.

As many of the professionals working within the Local Authority had found it difficult to engage with Slovakian young people in schools and with their families in the community, it became more relevant for the locality team (consisting of Educational Psychology Service, Ethnic Minority Achievement Service, Education Welfare and Family Action) to understand the Slovakian Community and to indentify factors that hindered their access to community services, to the educational environment, and to identify current good practice that promoted their engagement.

This led to the development of the E2L project, which consisted of the above named professional agencies who aimed to gather questionnaire data to identify the views and experiences of the Slovakian young people who had been identified as hard to engage with. These individuals were defined as those young people who were truanting from school and who did not engage with the professional Slovakian support staff located within the secondary schools in the local area.

The TEP's role within this project was to indentify the views of the Slovakian families whose children had been identified as hard to engage as further discussions with Education Welfare professionals indentified that the parents of these young people were also hard to reach. This led the E2L project to consider the level of engagement experienced by these families with regard to accessing the different services that were offered in the community.

Before any research was conducted it was important first to identify which individuals could be defined as "New Arrivals". Next, the team needed to identify what existing research could harnessed that related to the views and experiences of Newly Arrived children, young people and families into the United Kingdom. Finally, the team needed to ascertain what research was available with regards to the role of Educational Psychology when working with families who are Newly Arrived into the United Kingdom.

The search strategy began with researching "New Arrivals" and "Newly Arrived" through the search engines ASSIA and Swetswise; both these search engines identified 53 articles in total. From these articles, two were found to be relevant as they used the terms Newly Arrived. The other articles talked about Refugee and Asylum Seekers. The two articles references were utilised which also highlighted other relevant literature.

The literature review below discusses the research under the three main aims described above: defining New Arrivals; identifying relevant research into experiences and views of families, children and young people who have Newly Arrived into the UK; and finally the role of the Educational Psychologist within this field of research.

Defining the term 'New Arrivals'

The history of the Slovakian community's migration to the United Kingdom (UK) is most often associated with their split from the Czech Republic in 1993. After this separation, for five years the Country's Prime Minster, Vladimir Meciar, was seen as hostile and racist towards many minority groups such as Slovak Roma communities. This led to the UK seeing an increase in the number of asylum applications between 1997-1999. Most Slovak Roma migrated to areas in the UK such as Kent, Greater London, Southend and the North East (Rutter, 2006).

Whilst conducting the research review the author noted that much of the policy and legal definitions in earlier research were aimed at asylum seekers and refugees. For example, DfES 2004b and Office for Standards in Education, Children's Services and Skills (OFSTED) 2003, (cited in Hulusi and Oland, 2010).

Before commencing a discussion regarding New Arrivals, it is important to conceptualise what is meant by the term "New Arrivals". According to the Department of Education's (formerly known as the Department for Children, Schools and Families) 2007 publication 'Guidance for New Arrivals: Excellence Programme', New Arrivals are defined as:

- International migrants including refugees, asylum seekers and economic migrants from overseas.

- Internal migrants including peoples joining school as a result of moving home within the UK. For example Gypsy, Roma, and Traveller peoples.

- Institutional movers which include pupils who change schools without moving home, including exclusion and voluntary transfers.

- Individual movers such as pupils who move without their family. For example, looked after children, unaccompanied asylum seeker children.

(DCSF 2007, page 4)

The above definition can be viewed as a positive step forward as it includes groups who do not necessarily fall into the more commonly cited definitions in the literature regarding International Migrants, such as asylum seekers and refugees. According to Hulusi and Oland (2010) the definition of "newly arrived" therefore allows the same considerations to any child or young person who arrives into a school setting outside of normal admissions timescales (2010, 343).

Research into the experiences of Newly Arrived families, young people and children into the United Kingdom

Research into the experiences of children, young people and their families who are newly arrived in the UK is limited (Hulusi and Oland, 2010). The research that does exist focuses on specific groups of asylum seekers and refugees.

According to Rutter (2006), this research can be categorised into four areas. Firstly, there is the psychological or therapeutic work based on trauma which includes interventions to support children who are defined as having had previous, traumatic experiences. Secondly, there is research regarding children's resilience and vulnerability, and interventions put into place are based upon promoting their resilience. Thirdly, there is multi-disciplinary research conducted on refugee children's identity and adaptation, drawing from ethnographic studies, personal interviews and psychological assessments. Finally, there are interventions that focus on providing greater parental involvement in young people's and children's schooling.

Research such as Maegusuku-Hewett et al. (2007) and Hulusi and Oland (2010) has attempted to understand the experiences of newly arrived young people. Maegusuku-Hewett et al. (2007) interviewed 47 9-18 year olds about their experiences of life in Wales. They looked at factors that impacted on the young people's resilience and found that individual characteristics and wider ecological systems such as social relationships, societal and cultural norms and values were key factors in their level of resilience. The limitations of this research include, firstly, no clear definition of the children who were interviewed. For example, they were identified as refugees, but no further information was provided. Also the use of terms such as 'resilience' were not clearly defined. These factors thus impact on the generalisability of their findings.

The role of ecological systems such as the school environment is explored in research such as Hek (2005) who interviewed 15 students from two secondary schools in London. Hek (2005) stated that schools can make a real difference to newly arrived children (in this study they were defined as refugees), particularly with regard to their ability to settle and regain a sense of belonging. The study found that the school factors that helped the children feel settled

included the presence of specialist teachers who spoke their first language, support from pee groups and the general school attitude towards refugees.

These results support the role of the school system and professionals who work within it ir referencing the experience of children and young people who are newly arrived in the UK.

Overall it appears that there is limited research which focuses on the views of newly arrived families, and the research that is available focuses predominately on the experiences of asylum seekers and refugees, with a specific focus on areas such as post traumatic stress, resiliency and vulnerability factors. There are gaps in the research, specifically with regard to children and families who are newly arrived in the UK but who do not fit into the categories discussed by Rutter (2006) above.

There does exist some limited research into the issues faced by educators engaging with 'hard to reach parents, including ethnic minority and socially and economically excluded communities, following government initiatives to increase parental involvement in education.

Parental Involvement in Education

Over the years, research has discussed the nature and degree of parental involvement in education. Although a number of studies indicated that most parents are orientated towards their child's education and academic progress there are some parents who do not become involved. According to the Department for Educational Skills (DfES, 2002) report, although the government has made a number of efforts to provide parents with the skills required to

play a part in their child/children's education there is still a long way to go as there are stil many parents who are far less engaged or involved with their child's education.

Parental involvement within the literature is discussed in a number of different areas. Firstly there are descriptive studies that summarise the ways through which parents are involved in their children's schools (Epstein 1992 and 2001). Secondly there are outcome-based studies that show the positive correlation between parental involvement and students' academic performance or other positive outcomes (Fan and Chen, 2001), and thirdly "at-risk" studies that examine populations with lower-than-average parent involvement, such as ethnic minority groups or families seeking asylum (Crozier, 2001).

Based on empirical research, Epstein (1992, 2001) has distinguished six types of parental involvement reflecting different types of co-operative relations between schools and parents:

1. Parenting: This includes schools helping parents with the creation of positive home conditions to promote the development of children. For parents this includes preparing their children for school, guiding them and raising them.
2. Communication: This states that schools must inform parents about the school programme and the progress of their child/children. Schools must also present such information in a manner which is comprehensible to all parents, and parents must be open to such communication.
3. Volunteering: This applies to the role of parents and their contribution to school activities (e.g. reading partners, organisation of celebrations).
4. Learning at home: This includes activities aimed at helping and monitoring the learning and development of school-going children at home (e.g. help with homework).

5. Decision-making: This suggests the involvement of parents in the policy and management of the school and the establishment of formal parental representation (e.g. school board or parent council memberships).
6. Collaborating with the community: This includes the identification and integration of the community resources and services with existing school programmes, family child-rearing practices and pupil learning.

(In Driessen et al; 2005 p 511)

Although Epstein (1992 and 2001) offers a description of what parental involvement refers to, some researchers such as Crozier (2001) argue that such descriptions are limiting and marginalise some parents in society, particularly those who are already disadvantaged and that a "one size fits all" approach is not possible. Authors such as Crozier (2001) argue that different socio-economic factors, gender and ethnicity have an impact on the level of parental involvement observed in research findings.

According to Driessen et al (2005), strengthening the cooperation between schools and parents appears to be critical to improving the school careers of disadvantaged groups such as ethnic minorities and low socio-economic status pupils.

More specifically, a subset of "hard to reach parents" is currently not being effectively targeted by government initiatives. The term "hard to reach parents" is a phrase usually used in relation to parents who are deemed to inhabit the fringes of school, or society as a whole; who are socially excluded and who seemingly need to be brought in and re-engaged as stakeholders (Crozier and Davies, 2007 p 295).

Crozier and Davies (2007) conducted a study with a sample group from UK-based Bangladeshi and Pakistani parents. In their study, educational professionals and teachers had described the Bangladeshi parents as especially hard to reach. According to Crozier and Davies, (2007) although these families were described as hard to reach they were not difficult, obstructive or indifferent but could account for the lower than expected level of interaction between home and school due to cultural differences and language barriers. They felt that the government policy and subsequently school policy identified the role of the parents within a narrow framework, with an expectation that parents and their involvement have to fit a particular set of criteria (Crozier, 2001). Therefore, the complexity of the different types of involvement in which parents may engage is not acknowledged and nor is the diversity of the parent body.

Crozier and Davies (2007) conducted a qualitative study consisting of semi-structured and unstructured interviews with parents of children in Year 6 primary school, secondary-aged pupils and post-compulsory students. 591 parents and children were interviewed and twenty case studies were followed up over a period of six months.

The results indicated that the Bangladeshi parents felt that they had little contact with the schools. Most Bangladeshi parents interviewed did not see the need to visit the school or in many cases attend parents' consultation meetings. They stated that if there was a problem they would hear about it either directly from the school or through the community as many of the children in this study went to schools where there were other children from the same ethnic group.

From the Pakistani community, according to Crozier and Davies (2007), actual contac between the parents and the school varied between families and between schools which were identified into three types of parental behaviour.

1. Parents as consumers: these parents actively chose their children's secondary school. They had some knowledge about the individual schools and had knowledge of their children's education. They attended parents' consultation meetings but rarely anything else. They provided extra support to their children through resources and private tutors in so far as they could afford to do so.
2. Independent parents: these parents maintained minimal contact with the school. They sometimes attended parent consultation meetings but rarely went to the school for any other reason. They knew little about what their children did in school.
3. Non-participant parents: these parents had virtually no contact with the school; they rarely, if ever, went to parents' consultation meetings. They tended to leave educational decisions to the children and knew little about the education system or the significance of the different stages of their children's education.

This research highlighted that very few parents initiated contact with the schools and in most cases made limited demands on the school. As concluded by other studies, (Driessen et al, 2005 and Crozier, 2001), social class and gender were key factors in the extent to which parents were proactive. Whilst few mothers were proactive, middle-class fathers and fathers who were active in the community did initiate contact.

From the above, it can be concluded that whilst the government has created numerous initiatives to increase parental involvement in education, there are subsets of parents who

l involvement include socio-economic level, ethnic group and gender.

eeds to be greater clarity about what constitutes parental involvement i

Educational Psychologists' Role with newly arrived children and families

There are many areas of support that psychologists can offer when working with Refugee/ Asylum Seeking/ Newly Arrived children, young people and their families (Papadopoulos 2002; Ehntholt and Yule, 2006). An example would be school-based interventions such as work which falls within the remit of government initiatives and policy in both education and health to include socially disadvantaged groups (DFES 2004; DoH 2003). More specifically, local authorities are now expected to provide psychological support for International Migrant children within schools (Office for Standards in Education 2003). Often, for these children, the school one of the few places where they can experience consistency and emotional containment. Therefore, psychologists play a role in liaising with school staff to share information, to help with initial assessments, and collaboratively plan a programme of intervention and support (Ehntholt and Yule, 2006).

The Excellence Programme (DCSF, 2007) highlights areas of good practice that schools are already engaged in. Principally, this aims to address the general needs of pupils and help this level of support to become part of the everyday school curriculum and practice. These areas of good practice include admission and introduction procedures, effective communication with parents using interpreters and translated information, buddy systems and the use of welcome and inclusion activities in the school curriculum which explore the nature of the Refugee experiences (Bolloten and Spafford, 2003). It is also viewed as good practice for psychologists to raise awareness of the emotional needs of refugees at a whole school level via multi-disciplinary liaison meetings and training (Rutter, 2006).

According to Webster and Robertson (2007), emotional distress and stress from poor housing, poverty, and the threat of deportation or dispersal all impact on the well-being of newly arrived children and their families. Therefore, psychologists could be working towards bringing these issues to the attention of school staff and assisting them in thinking about the link between these problems and a child's psychological well-being within the school environment (German and Ehntholt, 2007). It is important to note that despite these difficulties and challenges, many refugee/ asylum seeking and newly arrived children are extremely resilient and perform well at school (Rutter, 2003).

There are many psychological theories and frameworks that can help to inform understanding of the views and behaviours of individuals, such as Behavioural Psychology and Cognitive Psychology. There are also wider ecological frameworks that can help professionals to understand the important systems that play a key role in the experiences of young people. In order to understand and discuss the views of children and young people who are newly arrived into the UK it is important to understand the views and beliefs of their communities within these complex systems. In the next section of this paper community psychology is discussed as a theoretical approach that can identify and attempt to understand communities as a whole.

Community Psychology

It is not possible to write about any one community psychology model or approach, as community psychology varies across the world (Burton and Kagan, 2005). Community psychology within the UK has been highlighted early on through the work of Bender (1976)

in a paper on the role of the community psychologist within educational psychology services. In stating that the community was the most relevant base for a psychologist's operations, Bender (1976) defined community psychology as an attempt to make the field of applied psychology more effective in its delivery of services and more responsive to the needs and wants of the communities it serves.

The history of community psychology (CP) has included forays into a broader field of preventative psychology, such as empowerment psychology, organisational structure and the ethos of public services (Bender, 1976). Community psychology does not view the individual as an isolated case, rather that the individual has to become familiar with and utilise all of the resources that are available to them in the community. CP often draws on the ideas of social constructivism, particularly when addressing issues of differential power and knowledge (McNamee and Gergan, 1992). When linking community psychology and working with disadvantaged families, Orford (2008) states that community psychology as an approach is congruent with communities' own constructions of school and education, as it allows professionals working with individuals to think about them within collective contexts and the ways in which those collectives (communities) are disempowered and how they can become empowered.

The key principles of community psychology theory and practice have been described by Orford (1992) in the following ways:

1. Assumptions about causes of problems: An interaction over time between person and social settings and systems including the structure of social support and social power.
2. Levels of analysis: from micro-level to macro level. In line with the level of the organisation and the community or neighbourhood.

3. Research methods: include quasi-experimental design, qualitative research action research, and case study methods.
4. Location of practice; as near as possible to the relevant everyday social contexts.
5. Approach to planning services: proactive, seeking out assessing needs and special risks in a community.
6. Emphasis on prevention rather than treatment.
7. Attitude to sharing psychology with others, positive towards formal and informal ways of sharing, including consultation.
8. Position on working with non-professionals is strongly encouraging.

Applied psychology has predominantly leaned more towards an emphasis on assessing and modifying the behaviour, emotions, and cognitions of individuals. In practice and research, work is conducted with individuals to ascertain their views and how they can change themselves. Although family systems are occasionally considered, rarely does psychology consider the work place, the school, links between home and school and work, the neighbourhood, community and society. Community psychology aims to correct these individualistic biases and aims to consider the social and community contexts of which they are a part of, and which influence them as suggested by Bender (1976).

The concept of community psychology encapsulates the aspiration of providing the whole community with an integrated psychological service that will be part of a fuller and more effective provision offered by professionals from many agencies, all working together for the benefit of the community (Webster and Robertson, 2007). It is a concept that embraces values and beliefs about fostering human welfare and about breaking down institutional barriers (Orford, 2008).

Within the theory of Community Psychology there are three key concepts; power, liberation and social justice. Empowerment has occupied a prominent position in CP theory, and within the literature is defined in the following ways:

"Empowerment is a process by which people, organisations, and communities gain mastery over issues of concern to them" (Rappaport, 1987 p 2).

"Empowerment is the aim toward which we strive, a state of affairs in which people have enough power to satisfy their needs and work in concern with others to advance collective goals" (Prilleltensky et al., 2001 p 145).

interventions. Thus, a universally applicable measure of empowerment is not possible (Zimmerman, 1995 cited in Orford, 2008 pg. 41), as what constitutes empowerment is likely to differ for different populations of people according to, gender, ethnicity and social class background.

Other concepts include liberation and social justice, both which are linked to how, in order for psychologists to understand the families and individuals they work with, they must understand the key influences that impact on their oppression in society.

Recent studies within two London boroughs (Webster and Robertson, 2007 and Savcic-Sanders, 2003) have discussed refugee communities and community psychology as an approach that attempts to recognise the social and political realities that are integral to the experience of New Arrivals/ Refugees and Asylum Seekers and seeks to intervene accordingly. According to Webster and Robertson (2007), the needs of these communities can be met through community psychology as it offers psychologists and other professionals the chance to provide services which focus on the community rather than on individual clients. Webster and Robertson (2007) carried out consultations with refugee community organisations (RCOs) in Lambeth. The consultations sought to elicit responses to the questions relating to the communities' conceptualisations of mental health problems, how they are dealt with within their community, and what support services could be offered to them in order for them to deal with any mental health problems. Similar need assessments have been carried out in Waltham Forest (Harris & Maxwell, 2000), Great Yarmouth (Bowden *et al.*, 2004) and Newham (Savcic-Sanders, 2003).

The following strong themes emerged from the Lambeth consultations:

- Many respondents reported considerable stigma around mental health within their communities, serving as a barrier to help-seeking.
- Depression (not PTSD) was repeatedly cited as a common problem and linked with isolation, lack of opportunities, racism, loss and adjustment.
- Family problems and relationship breakdowns were also frequently mentioned, often related to changes in gender roles.
- Respondents painted a negative picture of their experiences and perceptions of statutory mental health services.
- Concerns were expressed about information provision, difficulties in accessing services, poor communication with patients and their families and cultural appropriateness of services.
- Suggestions to improve services related to these above concerns. The need for more alternatives to medication, in particular talking therapies, the need for more training and education and the need to work in partnership were emphasised.
- The strength of social networks, family, places of worship and the commitment of volunteers were mentioned as being factors which promoted good mental health.

The results of this consultation were used as the basis for an action plan for South London and the Maudsley NHS Trust, in a bid to develop community psychology services for refugees in partnership with RCOs, and to deliver a series of community-based workshops that looked at service provision and stigma. Strategies were developed to manage the interface with the mental health system and to initiate conversations within communities

regarding the stigma attached to mental health problems. Feedback received indicated that the workshops served to facilitate communication between various refugee communities and to reduce a sense of isolation through the sharing of experiences and strategies.

Although the work of psychologists has traditionally been viewed as working with individuals, wider perspectives of psychologists work include their role within the community, which includes a focus on empowering parents. Government initiatives such as 'Surestart' for example are aimed at addressing poverty and enabling socially disadvantaged families with young children to access early years provisions. However, for many Newly Arrived parents, knowledge of these services and access to them can be problematic for a variety of reasons including language/cultural barriers, socio-economic factors, or through simply not living within a Surestart catchment area (Webster and Robertson, 2007).

The establishment of Refugee Parent Support Groups (RPSG) is another good example of community psychology and empowerment practice. Community psychology offers the opportunity to apply psychological knowledge and skills to improving the mental health of communities in ways other than traditional psychological therapies (Orford, 2008). Community Psychology is often referenced with a set of principles outlined by Orford (1992).

Although Webster and Roberston's (2007) study was a small scale empowerment project which focused on mental health services for the community in South London, it did highlight the importance of liaising directly with communities to identify individual needs and ways forward when breaking down cultural barriers. This links to the current project where the Slovakian community is often viewed as isolated and withdrawn from educational services.

Other projects of collaboration and empowerment of refugee communities designed to enhance social networks and support include the Newham project (Savcic-Sanders, 2003), where clinical psychologists offered training, support and consultation to volunteers from refugee communities. The results highlighted that the activation of social support networks (through empowered refugee volunteers) appeared to be a protective factor in the decrease of stigmatization of mental health problems in this group.

Another illustration of community consultation is a project aimed at understanding the mental health needs of refugees and migrant workers in Great Yarmouth (Bowden *et al.*, 2004). Based on the findings of this consultation, an action plan was developed to address the experiences and conditions that were perceived to contribute to mental health problems.

Criticism of such work includes the needs analysis conducted in the examples above, which led onto the delivery of actions plans for working collaboratively with communities to tackle the various issues raised. However, such plans are dependent on the assumption that there is a coherent notion of 'community' and that refugee clients wish to be connected into these communities. Mistrust, political divisions and stigma around mental health may militate against this, as could be the case with any group.

These studies can be criticised as they focused on mental health within communities where access to mental health services was limited. Within the school context this is not the case, and thus the context of empowerment for communities would be different when exploring parental involvement with their children's education. Although the above studies were small

scale qualitative pieces of work, they do help to build a body of research which could provide the basis for evidence based practice and provide services with good practice guides.

Criticisms or challenges to community psychology include, firstly, the lack of coherence regarding a clear leading model of community psychology, although Orford (2008) does offer a model based on many different sources as diverse as clinical psychology, applied social psychology and core ideas from outside the psychology discipline, he believes there is some consensus beginning to emerge which he describes as the model of 'community psychology' (Orford, 2008, pg. 379).

Secondly, criticisms include the fact that community psychology is too idealistic and works with the pre-notion of community cohesion which may be disputed. Thirdly, there is a belief, shared by many in community psychology, that the knowledge needed for practice in this field is likely to come largely from hearing from people about the reality of their lives. Although quantitative studies are possible, qualitative methods fit better with the overall principles. This is, therefore, another criticism of the research summarised above, for , as with all qualitative research, the objectivity of the researcher is limited and, therefore, studies which report on the lives and experiences of their participants are not without some level of subjectivity from the researchers.

appropriate comparison groups, multiple outcomes, and the implementation of diverse strategies and initiatives (Hausman, 2002). Whereas quantitative and action based research

Background and context to the E2L project

According to the professionals involved in this project the Educational Welfare Service (EWS) was finding it difficult to access the homes of the Slovakian families as many avoided visits and phone calls, largely as a result of negative community views of the EWS. The Ethnic Minority Achievement Service (EMAS) was unable to work with individual pupils as their attendance was a real concern, and again they also found access to the family home was limited. The Family Action Service (FA) had received a number of referrals regarding young people, but again was unable to gain the support of the families, which thus limited their work with the young people.

A clear theme was emerging which included difficulties for professionals in engaging with families, and as a result, work with the young people was less effective. Many of the young people had been described by school staff as persistent truants and were generally gaining negative press from school staff and other pupils. They were seen as young people who did not care about education and did not want to follow the school rules and routines.

The above named services were already identified as not only key in understanding the needs of the community and in providing support within schools for the young people, but in also offering advice and sharing good practice with staff working in the educational settings.

The role of the Senior Educational Psychologist was to co-ordinate and bring together the services, and to support professionals to work more collaboratively, to understand the views regarding education from the community as a whole, and to promote education inclusion of the Slovakian children and young people in the educational settings in the area.

As a team, the EPS, EWS, EMAS and FA perceived that in order to develop a way forward, the completion of a needs analysis was important, as in order to work effectively with the community, a deeper understanding of their needs was crucial, given that the current needs identification had clearly become ineffective.

The principal aims of the project were to identify: how the young people and their families felt about the education provision, what forms of support they found useful, and how these individuals could be better supported. These main aims were then developed into 3 research questions.

The key questions that the team considered important to investigate included:

For young people:

- What are the views and experiences of the Slovakian young people of their secondary school?

- What has helped to make their experience positive and what has hindered their overall experience?

For parents:

- What are your views and experiences of your child/children's education?
- What has helped you to establish a positive relationship with the services offered?
- What else do you feel would help you to feel supported by the school and professionals involved with your child's/children's education in the future?

The research questions that were identified for the young people were addressed through a questionnaire survey conducted by the EMA staff. The summary of their findings is documented below.

In total 29 secondary school pupils completed the questionnaire (Appendix 1) and the results of these are summarised in Appendix 2. A summary of the findings is also provided where the key themes identified are presented below:

- Most students reported attending school every day
- All students stated that they were aware that students needed to attend school every day.
- 28 students stated that they attended school when they were living in Slovakia (only eight had any pre-school experience, most of the students stated that had started school at primary age 5-6).

- Most of the young people responded stating that they had good school attendance when they were in Slovakia.
- Things that they valued about school in Slovakia included having friends and not having to wear a uniform.
- Things that they valued about their current school included some of the teachers, using computers and some friendships.
- Things that they did not enjoy about school here included teachers who were not helpful and who shouted, name calling and some racist comments.
- 60% of the young people stated that they felt safe at school.
- 40% stated that they were concerned about fighting and aggressive behaviour from other pupils.
- Young people stated that the EMAS /E2L teachers and other Slovakian students made them feel settled at school.
- 60% of the students stated that they were made welcome in the school by other students.

The questionnaire identified a number of interesting themes. Although 60% of the sample reported feeling safe at school, many comments were made regarding racist bullying and aggressive behaviour from other students and 40% of the sample stated that they were concerned by this. Many of the young people surveyed valued the input from the EMAS/E2L staff and valued being part of a Slovakian peer group.

To gain information to answer the research questions summarised on page 27-28, the team felt that semi-structured interviews would be the best approach for obtaining the families' perspectives and their feelings around some of the highlighted issues.

The role of the TEP within the project was to gather information regarding the parents' views in collaboration with an interpreter who was also a respected member of the Slovakian community.

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The TEP chose semi-structured interviews as the method of data collection as this created some flexibility in the interview process but also offered a structured framework for all interviews. The use of an interpreter was also viewed as essential to bridge the communication barrier.

The semi-structured interview as a research tool is defined by Robson (1993 pg 228) as:

"A two-person conversation initiated by the interviewer for the specific purpose of obtaining research-relevant information, and focused by him on content specified by research objectives of systematic description, prediction, or explanation."

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Robson (1993) describes interviews as serving three purposes; firstly as the principal means of gathering information that has a direct bearing on the research objectives. Tuckman (1972) describes interviews as a method of providing access to what is inside a person's head and of gaining information relevant to the person using their own words, thus allowing the researcher to understand what a person thinks and values. Secondly Robson (1993) states that interviews can provide information to test hypotheses or suggest causal relationships between variables. Thirdly, interviews may support methods of data collection in a research project.

Ethical considerations, included the need for informed consent by the parents participating in the research. As a translator was used, the TEP felt that it was important that the person who was translating was aware of the code of ethics that psychologists conducting research work within (BPS, code of ethics ref). The TEP ensured that parents were aware of the research and they were asked to give oral consent on the day of the interview. The interview then continued with their verbal consent. The families were also given information regarding the interview data; it was explained to them that these data would be annoymised and that only the TEP would have access to the raw data.

Participants

The sample used in this study consisted of Slovakian parents who had arrived into to the UK between the years 2004 and 2009 and who had children attending a secondary school in the local area. The families in this sample where highlighted through the EWS, FA and EPs as their children had been highlighted as persistent school non-attendees.

In total six families agreed to be interviewed out of a possible fifteen. These parents were of young people identified by the Educational Welfare Service as persistent school non-attenders. However, on the day of the interviews only three parents were available during home visits. A brief description of each family is described below:

Parents	Description
A (participated in the study)	Mother of two Slovakian girls who both attend secondary school, 1 pupil is Year 7 and the other Year 9. Both pupils have been truanting and have been involved with the EWS for some time. Parent A has another young child whom she looks after, as the father is away working for most of the day. They arrived in the UK in 2007.
B	A mother who has been in the country for three years and has two children, both boys, one who is aged 14 and attends the local secondary school and a younger boy aged 7 years. Her husband is still in Slovakia and hopes to come over soon. They live in temporary accommodation provided by the local authority.
C (participated in the study)	Both parents have been in the UK for over 7 years and both work. They have three children: a boy aged 9 years, a girl aged 13 years and a boy aged 15 years. The parents have both been involved with the EWS for issues with their eldest son's persistent truancy.
D	Parent D is a young mother with a step-son who attends the local secondary school. She is pregnant with a new baby and has been in the UK since 2006.
E (participated in the study)	Both parents arrived in the UK in 2007 and work full-time. Their son and daughter attend the local secondary school and the son has had fixed-term exclusion for not wearing the correct uniform and for walking out of lessons.
F	Parent F is a mother who has one daughter who attends the secondary school. They arrived in the UK in September 2009 and the young girl's attendance is a real concern to professionals and school staff.

"A method for identifying, analysing, and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail" (Braun and Clark 2006 pg 79).

Braun and Clark (2006) suggest that thematic analysis is widely used informally in the world of psychology research, but that there is no clear agreement about what thematic analysis is and how researchers go about doing it. This approach to data analysis was chosen by the researchers because of its flexibility, as other methods of data analysis such as grounded theory (GT) rely heavily on grounding the research findings in theory. Due to the nature of the action research project, using a GT analysis approach would have been a time consuming analysis and the small sample size would have limited the application of the results to wider contexts which GT suggests.

For an overview of thematic analysis and the six stages used by the TEP please see Appendix 4.

The main themes that emerged are presented under each interview question:

What are your views and experiences of your child/children's current education?

Emerging Theme	Qualitative Description
Getting a good education is important	"I really want them to get a good education", "I think it's good that my son will be able to get a good education and get a good job", "I am glad my children are being educated here as they get a chance to learn English."
The education system in the UK is better than Slovakia	"I feel that the education in the UK is much better then Slovakia", "I think the education here is better than Slovakia", "The education is good here."
Bullying is an issue in my child's current school	"I think they don't like it because of bullying, they are always coming home and saying that other children make fun of them, their accents, their clothes and I think that's all", "Bullying was an issue when he first started the course."

What has helped you to establish a positive relationship with the school and other services?

Emerging Theme	Qualitative Description
Support from the E2L staff has been	"When the girls first attended the school we found

Having access to a Slovakian support teacher at the school has been beneficial	"Also the teacher in the learning support base who spoke Slovakian was also good", "because they have Slovakian teachers", "It's good that we have been offered interpreters", "The E2L teacher who comes to the house is good we appreciate her support."
The opportunity to share our experiences has been helpful.	"What has helped has been you coming here today and giving us an opportunity to tell you our side of the story", "I also have appreciated this discussion today."
Positive comments from other Slovakian families within the community have helped our view of the school.	"The reputation of the school from what other parents tell me has helped me feel positive about the school."

What else do you feel would help you to feel supported by the school and professionals involved with your child's/children's education in the future?

Emerging Theme	**Qualitative Description**
More opportunities to discuss their	"I think more opportunities to talk with the school

with the school, with the support of a translator.	could invite parents in as a group to talk about some of the issues with a translator."
Discussing the issues regarding children's truancy early on so that they can become involved from the start.	"It would be good if we were notified soon as it means then that we can do something on the day", "I also think more opportunities to be involved when the truanting happens not afterwards would be good."
Positive friendships would support the children's engagement with the school at a social level.	"He doesn't have that many friends in school", "I think if he had more friends he would be happier in school then maybe he would not truant so much", "I know there are problems with not going to school and bullying."

The main themes emerging from the interviews conducted with the parents included firstly that all three parents valued the education that was provided for their children and felt that the education in the UK was better than the education received in Slovakia. They also highlighted their concerns regarding bullying; this concern was also raised by the young people in their questionnaire responses.

Discussion

community views and that positive comments from other families in the Slovakian community helped them feel positive about the school. The parents in the interview stated that having positive peer relationships and being notified early about their child's absence from school would support their children in remaining in school.

Discussion

This paper presents The New Arrivals/E2L project which aimed to identify the views and experiences of Slovakian parents with regard to their children's education and support services, to enable them to become more involved in their children's education, and to support their attendance at school.

The results of questionnaires and semi-structured interviews highlighted that young people and their parents viewed the education in their current school as positive, and welcomed the support of the E2L staff, particularly the support of translators. Respondents also highlighted some of the positive aspects of their integration into the school environment such as being paired with other Slovakian pupils. This corresponds with what has been suggested in the DCSF (2007) excellence programme: 'New Arrivals', which highlights that effective communication with parents using interpreters and translated information and buddy systems are positive interventions to support the inclusion of these groups (Bolloten and Spafford, 2003).

Parental views highlighted their constructions of education and school attendance and all the parents interviewed appeared to have positive views of education, linking their child's education to future job prospects. Two of the three parents interviewed in this project had been educated to the age of 18 in Slovakia and understood the need for their son/daughter to stay in school. However, in regards to parental involvement it was clear that the Slovakian parents were not as involved in their children's education, when compared with parents from different socio-economic backgrounds (Epstein, 2001).

Reasons for their children's disengagement with school were linked to bullying and a lack of positive peer relationships. This issue was also raised by pupils and by the professionals involved in the project, suggesting a need for further support and action planning to discuss this issue with school professionals.

Another theme raised predominately by the three parents interviewed was that their views of the school were influenced by the perceptions of other community members. For example, one parent stated that what helped him/her view the school in a positive way was the opinion of other Slovakian families whose children were at that particular school. When discussing this theme in relation to community psychology, it appears that at least for the families interviewed as part of this project, the views of the community were important to them. This corresponds to Orford's (2008) views on community psychology, where communities are often the key link to whether individuals feel empowered or disempowered.

These finding also correlate with the conclusion drawn by Crozier and Davies (2007) who also found that Bangladeshi parents kept in touch with their children's education via word of

mouth through their community. This suggests that community views have an influence on "hard to reach" parents and their level of involvement in their children's education.

Another theme raised during the interviews with the parents was that all three parents felt more opportunities to discuss their concerns about their son or daughter's education were needed. Although these parents could be described as "hard to reach" (Crozier and Davies, 2007) they welcomed more opportunities to engage with their child's/children's education. Ways in which they thought this was possible included the E2L project members coming to them to gain their views, and as a whole the parents hoped for more opportunities like this so that they could talk to school staff about concerns they had such as bullying.

important to note some potentially inaccurate assumptions held by school staff regarding the limited engagement of the families, labelling this as their not being concerned with their child's education. After interviewing the parents of three children it was clear that this assumption was not accurate. The parents did recognise the issues surrounding bullying and the implications of the EWS involvement. As stated by Crozier and Davies (2007) hard to reach parents are often viewed negatively by school staff and this can impact on their level of engagement with the school. Cultural and language barriers between the school and parents are misunderstood as lack of interest and enthusiasm for their children's education, when this is not in fact the case.

Overall there were a number of key factors that would be useful for school staff to become aware of in order to offer support to Slovakian young people and their parents. Firstly, the awareness that parents did hold the education system in the UK in very high esteem and had aspirations for their children to remain in education; secondly, that bullying was raised as a concern and a negative experience for the young people, which may be impacting on their level of attendance; Finally, to reinforce the positive view held by the parents and pupils regarding the Slovakian support staff working in the schools.

The limitations of the E2L project include, firstly, the limited number of parents involved in the interviews. Only three parents were available at the time of home visits and, therefore, the results are limited. Although a number of themes were identified, these were based on views from a small sample. As the content was specific to the Slovakian community within the local area, it is not possible to make wider generalisations.

Secondly, as noted by the E2L professionals, much of the research reported could be viewed as biased towards the families and children who were engaged with the education system and the professional agencies involved in the project. This could have been a reason as to why families who were available for interviews were able to discuss positive views about the school and the E2L professionals. The sample was, therefore, not representative as there still remained a number of families and young people who did not engage with the E2L services and whose views would have been important to develop the results of the E2L project further.

Finally, when reflecting on the role of Educational Psychology, the TEP noticed a number of challenges for EPs working in this way. Firstly, as professionals working within the same organisation, there appeared to be some initial animosity from E2L project staff regarding what the TEP could bring to the project. Defining roles was a challenge that was overcome through active communication from both the TEP and the E2L professionals as a means towards ensuring professionals felt clear at each step of the project about each other's role.

Finally a challenge to be negotiated following on from the research is the management of the next steps of the project and how information derived from the study should be fed back to school professionals without schools feeling negative and possibly unresponsive to the key messages being shared. Through discussions and problem solving the E2L project professionals decided to disseminate the information in small pieces to the secondary school where the project took place as a starting point.

Conclusion

Conclusion

As suggested by Rappaport (1987), performing research in the community provides researchers with an opportunity to gain an insight into the values, ideas and concepts held which can be used in promoting positive ways of working collaboratively with professionals. The professionals involved in the E2L project had, to some extent, felt that this had been achieved. Through interviews with parents and information obtained from a sample of young people, the E2L project had obtained valuable insight into the views and perceptions of these families. However, professionals involved in the project also noted that there were still a number of hard to reach families who had not been part of the needs analysis. Understanding their views and experiences of the education and services offered to their children was still an area for development.

The ways forward for the project included feedback to key staff members at the school where the project took place and to secondary school head teachers who would benefit from understanding the views of parents and young people from the Slovakian community.

The limitations of the project such as the limited number of parents who were available for interviews would mean that the results would need to be interpreted with caution. Nonetheless this information forms a useful starting point to begin to build a bridge between the home and school for the Slovakian families. In terms of the community as a whole, by empowering individuals and modelling good practice this could allow other families to begin to feel empowered through members of their own community rather than professionals

; into their community and imposing their own agenda without an understanding of the

and values of the community.

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APPENDICES

Appendices

Appendix 1- Slovakian Questionnaire

Appendix 2- Questionnaire analysis

Appendix 3- Transcribed Interview

Appendix 4- Thematic analysis

Yes ☐ No ☐

(Tick one box only)

If yes how often?		
	Every day	☐
	5 days a week	☐
	4 days a week	☐
	3 days a week	☐
	2 days a week	☐
	1 day a week	☐
	For a few lessons only	☐

4. Do you know that in England you must go to school every day?

Yes ☐ No ☐

Do you know your parents might have to pay a fine if you do not go to school?

Yes ☐ No ☐

5. Did you go to school in Slovakia before you came here?

Yes ☐ No ☐

If yes, what schools did you attend? *(Please tick all appropriate schools)*

6. If you went to school, was your attendance good or bad there?

Good ☐ Bad ☐

7. If you went to school in Slovakia, what did you like best there? *(Please list)*

8. What didn't you like at school in Slovakia? *(Please list)*

9. What do you like best about school here? *(Please list)*

10. What are the worst things about school here? *(Please list)*

11. Do you feel respected in school here?

Yes ☐ No ☐
If no why?

12. Do you feel safe in school here?

Yes ☐ No ☐
If no why?

13. What helped you settle into school in the UK when you first started school here?

14. Did the teachers and other students make you feel welcome when you first started school here?

Yes ☐ No ☐

If no, why?

15. What did it feel like when you first started school here?

16. Did you have any problems when you first started at school here? What were they?

17. What could schools do better to help new students when they arrive and afterwards?

When they arrive:

Afterwards:

Thank you for completing this questionnaire

Questionnaire of Slovakian Students October 2009

1. How old are you?
2. What Year group are you in at school?

Age	No. of students	Year Group
11	2	7
12	3	8
13	6	8
13	4	9
14	3	9
14	5	10
15	4	11
16	1	11

3. Do you attend school?

Yes [26] No [ ]

(Tick one box only)

If yes how often?		
	Every day	13
	5 days a week	5
	4 days a week	9
	3 days a week	
	2 days a week	
	1 day a week	
	For a few lessons only	

4. Do you know that in England you must go to school every day?

Yes [28] No [ ]

Do you know your parents might have to pay a fine if you do not go to school?

Yes [27] No [1]

5. Did you go to school in Slovakia before you came here?

Yes [26] No [1]

If yes, what schools did you attend? *(Please tick all appropriate schools)*

Pre School/Nursey/Kindergarten	8
Primary (5-10 yrs)	1
Primary (5-11 yrs)	1
Primary (6-8 yrs)	4
Primary (6-9 yrs)	2
Primary (6-12 yrs)	3
Primary (6-14 yrs)	1
Primary (6 -15yrs)	12
Primary (started Yr 7)	1
Special	
Other *(please specify if you can college for example)*	

If no, *say why*

* Then travelled about then came here. Had some lessons at Chantry for a few weeks.
* Some time spent in Belgium.

6. If you went to school, was your attendance good or bad there?

Good [24] Bad [1]

* Only when I was ill and it was authorised absence (2)
* Bad because we travelled a lot (Germany, Denmark)
* Did tests and exams.
* I went to school in Slovakia all the time. I loved school – it started later so I could have good sleep.
* I went every day.
* Yes 5 years, I was the best attender in the class.

7. If you went to school in Slovakia, what did you like best there? *(Please list)*

* I like DT
* Teachers OK
* Other children OK
* Don't have to wear a uniform
* All subjects, some teachers, didn't need to wear uniform. I miss my breakdance lessons (professional)
* Maths, I liked the teachers and the friends, I liked that we stayed in one classroom.
* Maths, PE, Slovak language, geography, not wearing uniform, I had tie, food cooked, teachers, strict but I liked that as I had better results.
* Maths, PE, Slovak language, food, no uniform.

* Sometimes, I don't remember. (3)
* Football, basket ball, and liked the teacher
* Everything, PE, football, good teacher, all subjects, german
* Everything, all the lessons, all the teachers.
* Everything – the lessons and teachers, I learnt German.
* The teachers were the best – the teachers helped me.
* I liked PE and geography, I liked the teachers. I liked it we stayed in the classroom and the teacher comes to us.
* Playing football. We danced a lot and learnt hip hop.
* Drawing, maths
* Biology, reading
* Dance, drawing in coloured pencil.
* Music, drawing, PE
* I liked how we worked, the lessons – literacy, maths, science, PE – everything.
* I liked Art, everything is good, teachers, no uniform, I could understand.
* I could understand the work was more easier. We could wear what we want.
* Everything, teachers, my friends, no uniform, liked to stay Slovakian.
* Geography, especially geography teacher. Always stay in the same class with the same child.

8. What didn't you like at school in Slovakia? *(Please list)*

* History
* Some teachers, more learning and more homework in Slovakia than in the UK
* Liked it all.
* Nothing (4)
* Teachers sometimes they hit us. No chance to learn any languages. There is possibility, but bad system, no good teachers, they know less than students.
* Don't remember. (2)
* It was all OK, prefer that the teachers came to our classroom.
* Nothing, I liked it all.
* I don't like swimming because the water was so cold.
* Teacher, she was bad.
* I didn't like reading and writing. The teachers in Slovakia were more strict than here.
* PE
* Maths, I wasn't good at it.
* Swimming, to do maths I don't like that in Slovakia because that is hard.
* Reading, writing, my teacher – she was lying and hit the children
* I didn't like when I was playing with my friend and other children "started" on us, then the teacher was fighting the children and they hit with a ruler.
* No, all was good.
* Nothing, I liked it. I got up at 6 to get there early and see my friends.
* I didn't like the biology part of science.
* Cant go outside in the playground – at break stay in the classroom.

ke best about school here? *(Please list)*

's are OK (2)
form, food
: good English, still getting my writing to sort out.
longer breaks, music
ering, I like learning, I like some of the teachers, I like some English,
vak boys.
eachers, Ms Lovering, opportunity to learn languages, opportunity
and good job.
re in UK is better opportunity and teachers to learn modern
:ter possibility for the future.
ght, homework is OK. I like music, art, DT. Some teachers are OK. I
od friends from Slovakia.
, music, uniforms, food (2)
till like football, basketball, play football in the park. Mrs Lovering.
nglish, PE, Computers
sons, I like drums, I like art. Some of the teachers are OK.
, sound and vision, I like registration teacher, Lucia, Denisa, teachar
e, communication, teacher at Discovery.
it here. But I have some friends. I like IT and humanities, art in
l teacher).
ns, especially photography and art.
g here and I like Art and RE. teachers are good. I got friends – just
d, China and .
s, technology, PE.
(the field to go to play football). I like to go on the computer at
nice friends. Sometimes the teachers are nice.

ce.
re, I like swimming here. The swimming pool is nicer here.
ood.
PE.
ers and everything. I have nice friends.
, some lessons, I like child development.
hotography. I like the teachers and these subjects – they help.
akian teacher. I like Mrs Ong. I like Art and Geography.
ave loads of friends here, not like in Slovakia when we were just in

vorst things about school here? *(Please list)*

it's alright.

* Students
* No girls.
* We finish school here at 3.00 pm where as in Slovakia at 1.00 pm, no girls, I miss Slovakia, I had enough of whole England
* I like it without uniform, some lessons are bad. Humanities, maths, sometimes the teachers shout it I ask for help. Sometimes the children call me names like Kosovan and sometimes they swear. I don't tell teachers, I tell Mrs Lovering. If they would punch I would punch back.
* Some teachers don't help, not so cold as in Slovakia, missing snow, racists students, calling us names.
* Students, racism.
* Don't like getting up on time to get here, don't like going to lessons, don't like changing, sometimes it is hard to remember to do homework.
* Some teachers, glass, some students. (2)
* Don't like fights, in lessons English children "start" fight. The teachers stop it. Sometimes English call me names.
* Nothing (2)
* I don't like the teachers, they are strict, they shout at me for no reason sometimes. I hate maths teacher – I like the lesson. Sometimes the other children are a bit racist, they call us stuff – Kosovan. Sometimes I do the noise in the lessons. I don't like PE. Don't like getting changed.
* Humanities, no good teacher, drama
* I don't like PE, Drama.
* The worst is the English students, they provoke me and say things like Slovak smell and they can go back to their country. Some teachers don't help.
* Nobody likes me. But I am happy. Some people call me 'coldie'. I don't like the teacher.
* All the lessons, I don't understand and don't have support. I would love to have Slovak TA to help me, I don't have her on any lesson.
* I like the system here more because we change classrooms here. I am doing English GCSE. I need to go to college automechanic.
* French, they don't teach us anything.
* I don't like PE because it is hard. I don't like the PE kit.
* PE, French – not a good teacher not good lesson. When they call us dirty, different names. When we tell the teacher she advises them to ignore. It happens every day.
* I don't like it in this school when people start on you and call you dirty. Sometimes I say it to them back – then I tell the teachers this happens just sometimes.
* The English children, every time they start I tell the teacher.
* The students are rude and call me names; they try to annoy me. They try to fight me. English drama is too hard.
* The children from England provoke me and swear at me a lot and haven't done anything to provoke them. Ignores it. Had a problem with a boy telling her horrid things, she told the teacher in the lesson and it stopped.
* Doesn't like being told to take off coat and scarf when staff tell her off. Having to wear uniform.

11. Do you feel respected in school here?

Yes	12	No	5	Not always	5	If no why?

* Some teachers and children don't show respect, the teachers are racist. They don't help, some shout. Some of the English children bully. Sometimes I start on them, sometimes I fight. Sometimes the teachers ignore. I only tell Mrs Lavering if others bully me.
* Many students wanted to fight me.
* Sometimes there are students who start with me, I tell Ms Lovering and she will sort this out.
* Some of them show me respect, but not always. The Slovakian boys show me respect.
* Some teachers don't respect us, some students don't respect us.
* It depends some students yes, some no, some teachers don't respect us.
* Sometimes teachers and children don't, they are racist, children call us things like Kosovans. Sometimes the teachers see it and stop them. Mrs Lovering helps at these times.
* Most of time – not when they fight.
* Yes, but sometimes students start to provoke
* Not from teachers or children, sometimes.
* Teachers respect us but not the students. Students tell us horrible things, and when we tell teacher, she shouts and nothing happens.
* They don't respect us, they say "don't come to me because you smell". I do nothing – just walk away. If we tell the teachers, nothing will happen, sometimes the teachers will shout at them, sometimes the teachers see it and don't do anything. I don't have friends like I do in Slovakia, so it is scary.
* Many teachers don't. The students that know me do respect me, the other ones don't.
* Half and half, some students don't like me.
* Sometimes no, when it is English children swear – they don't want to be friends to Slovakians – I don't know why. Teachers give respect when teachers give me respect I respect them.
* Only students, teachers respect me.
* Some teachers (almost all) they respect me but some kids don't.
* My English friends help me.
* Some teachers do but more don't. Only the students who go to lessons with me.
* Just some don't respect.
* Students that know her respect her. The ones who don't know her don't respect her.
* They think I am Polish for some reason, but they don't treat the other Slovakians nicely.

12. Do you feel safe in school here?

Yes	15	No	4	Not always	6

If no why?

* I do feel safe.
* I feel safe but not before. They leave me alone, teachers sorted this out.
* Sometimes the other boys say they are going to get us. Then I tell Ms Lovering and she sorts it out.
* Never know who and when they will attack you.
* Some of the boys are threatening.
* I start fight sometimes, I like to fight. (2)
* Sometimes I feel they will hurt me.
* Sometimes they might hit me. Sometimes there are fights. Sometimes I fight too.
* Not known surroundings, children start at us. They throw bread at us and they left.
* I don't have friends like I do in Slovakia, so it is scary. Big Asian boy started on us yesterday, throw bred at them.
* Sometimes, as some students are laughing at me and it makes me very sad.
* Sometimes, I don't feel safe on Friday – they are bad lessons on Friday. Sometimes I don't want to go to the lessons.
* Sometimes I can't get up to go to school, because I am tired.
* I think they are going to punch me.
* When I get here I feel like I don't want to work. I don't feel really well. I feel tired all the time. Some of the boys outside the school are like a gang and they try to fight us after school. I haven't told anyone that in the morning I feel sick when I stand up for school.

13. What helped you settle into school in the UK when you first started school here?

* Friends helped me, I couldn't speak English.
* Ms Lovering, Nikolas, Marcel, Miroslav
* Everybody, teachers, students, Ms Lovering
* Ms Lovering
* In Kings Farm the teacher helped me, but not here, they didn't help.
* Ms Lovering, friends.
* Ms Lovering, friends, some students.
* Primary school was OK. I could speak English when I went.
* Ms Lovering, Patrick, Alex
* Ms Lovering, Denis
* Mrs Lovering. Some of the teachers helped with work.
* One friend
* Someone helped me – Ms Lovering.

* Keisha, one boy from my classroom.
* No-body helped except Danielle, Mrs Ong.
* Was here in England for 2 years. Went to Chantry with one teacher. That was good, 3 days 3 hours. It was good to come to St Johns, my dad helped me. One English student helped me out and I followed her – no Slovak teacher or student helped me. I know some Slovakian but not in my class.
* One girl helped me, she looked after me.
* All students in the classroom, Mrs Ong, some teachers.
* The teachers, maybe Mrs Ong.
* Ms Ann Ong, friends.
* Friends from Slovakia, one teacher (she is in charge of something).
* The teacher helped me settle in- Mrs Lennard at Chantry, Mrs Ong at St Johns. The other children at Chantry were nice.
* One teacher (I don't know her name), Mr Gergely, some students I didn't know before.
* My friends, Mrs Cravder and Mrs Evans at Chantry.
* Some of the English students helped. Mrs Ong helped the most. Nobody gave me translations or anything.
* It was helpful at Chantry I learnt English in a little group, only Slovak, there was good. I felt safe. Miss was good she took us with the boat on the river. The kids get on my nerves, I hate it. They call us Kosovans.
* A friend was with me at the start. Mrs Ong.

14. Did the teachers and other students make you feel welcome when you first started school here?

Yes	17	No	9	Some	2

If no, why?

* The teachers were welcoming. Some of the children weren't.
* Patrick showed me way around. Teachers welcomed us.
* Teachers introduced her.
* Not every teacher. Some of the children did but many of them are nasty.
* They introduced me on the lessons
* Just treated me like the others. I was good when I first came.
* I was not introduced.
* Nobody welcomed me in the first lessons and said who I was. Nobody said anything, just shouted out names in the registration.
* Yes – 3 Afro-Caribbean girls made me feel welcome. No – the teacher ignored me, they didn't even think I was new, they thought me just like another student.
* Not everybody, some of the children said 'oh look Slovakia people' – not any more.
* Sometimes my friends did, nobody else did.
* I could speak a little English when I came.
* They didn't make me feel welcome. The teachers just said go and sit down.
* They have me some help with English. The best teacher was Mr Doherty he helped me.

* First day yes, then the children started to tease me about my bad teeth.

15. What did it feel like when you first started school here?

* Little bit scared.
* Confused, but Marcel and Miroslav helped me out.
* OK
* "Where am I"
* I was feeling made because every people swore at me.
* Scary, confused.
* Scary
* I was a bit scared, didn't know where to go. I had heard that big fights go on here.
* OK, I know people, students here
* OK I knew Denis from before, so it was easy.
* I felt scared and it was horrid. It was only Mrs Lovering helped me get to the right place.
* OK, I knew some students already
* A little bit scared.
* Not good, I didn't know anybody.
* I was happy, but I was lonely.
* I felt like I did in Slovakia, not scared.
* I felt happy, really happy.
* Scared.
* Not scary, I just went to lessons.
* Scared, I didn't know anybody, lonely, I didn't speak any English.
* At the beginning I was a bit scared, but next day I felt fine. I knew a lots of children so it made easy.
* It was not scary, it was happy.
* I was scared of English students.
* A little bit scared then it was OK
* I was unhappy, lonely and confused.
* It was hard, my friends helped me learn English. They found me an English boy to look after me.
* It was scary, very big school, didn't know where to go.
* A bit scary at first. I cried the first day. When I found friends it was OK. They put me with a girl LW to help.

16. Did you have any problems when you first started at school here? What were they?

* Problems with the timetable. I didn't understand in the lessons. I can't write well in English.
* Not many because I had good friends to help me out.
* Timetable
* English

* I didn't know where to go on the lessons. It was hard to understand the timetable. I was on my own.
* Timetable, where is the classroom.
* Timetable was difficult, finding the classroom.
* I had some problems with the timetable, I couldn't know where to go. (2)
* I knew older students, my brothers some there, they are older and they explained to me about everything and they looked after me.
* No problem, I knew English, have been at school before in English primary and friends helped me with timetable.
* No, no problems.
* With timetable – to change classes and find my lessons
* No problems.
* With English students, called us names, no friend, not knowing what to do.
* I had problem at the beginning with the children who said I smell. My internet didn't work.
* Problem with the timetable.
* No, in one day I knew what to do and where to go.
* With the timetable, not understanding lessons.
* He said that every time he comes to school he goes to registration but he doesn't know which teacher he should have.
* Yes, children provoked me especially boys, they called me names.
* With timetable, understanding lessons.
* No nothing was difficult, it was good.
* Not here as I already went to Whitehill.
* No problems, when I didn't know where a room was my friends helped.
* I had problems with my timetable, didn't know where to go. I didn't know the rooms. English was for me very hard. I was shy to speak English. I don't like the blazer, I hate blazer.
* Didn't understand, didn't know anyone. Problem with timetable and understanding timetable. Teacher told Nat to look after me, then it was better. Nobody helped her at all.
* Big problems with timetable and I came up on different registers.

17. What could schools do better to help new students when they arrive and afterwards?

When they arrive:

* Help with friends and lessons.
* Show them how to do work, where, which lessons to go to, helped them out with homework.
* Help with English language, Slovak TA and teacher to help.
* Club for Slovak students after school to learn only English, Slovak TA or teacher at the beginning to understand lessons.
* Have Slovakian friends. Send a boy to explain to him to sit with him, teach him how to write.

* More English lessons, make sure where to go, which lesson, understanding the timetable, make simple lessons.
* More English lessons, make sure we know where to go.
* I would like to start school later, like 10.00 am. Tell the teachers to stop the others calling us Kosovans. Give English lessons.
* To have some Slovak students there I never bunk.
* Have some Slovaks students here more help with lessons to understand.
* They could do more to help us in the class they could tell the other children about us. Make sure in lessons they help to understand.
* To clearly explain about timetable and help with it.
* Have some teachers that can speak Slovakian as well. Last year I used to bunk a lot – it was fun.
* Show their classroom, make friends, speak to them to find out what they need and do it.
* Show us the classroom, meet the teachers, give us a friend. Ask me what I need Learn my name.
* Employ lots of people like Denisa and Lucia so that they can help in the lessons.
* More help, especially with homework. Help for teaching English and reading an writing.
* With everything, with timetable.
* A person to take me to every lesson until I know my timetable. Do some practical – doing things – to learn English before going in to lessons.
* In everything.
* I would help them, I would take them to their lessons personally till they used to their timetables.
* Get some friends for them.
* Show them where to go, which lesson.
* Learn them how to speak English, how to read. Give them lots of friends.
* Make sure teachers know that the children are from other countries. When you come first day the teacher expects you to do stuff and you can't. teachers could be better trained.
* Help with English, to speak. Have some Slovakian teachers, help if the students can show where to go.
* Not to have to wait 1.5 years for a place. It is helpful if there is someone who can speak the language like Lucia and Denisa.
* Here a Slovakian, Polish etc person working in the school every day to come to the lessons all the time.

Afterwards:

* To befriend English students with Slovak, so they can catch better English and reduce problems, racism.
* Timetable.
* Keep on English lessons.
* Make sure they know which lessons to go to. A friend to help. Help with homework. Don't understand in lessons, the teachers must help.
* More help in class.

* One teacher in English and one teacher in Slovak on every lesson, so we know what's going on. Would love Lucia to come to every lesson and it feels like going to the lesson every day.
* Now it would be good to have one teacher in English and one teacher in Slovakian in every lesson. More help for writing.
* Keep on with the teachers.
* Basically more help with homework.
* More support in lessons.
* More English lessons – a timetable that is clear.
* More support in lessons, more Slovak support.
* Would get more help (TA) to understand lessons.
* Get the teachers to give more help to understand especially in maths.
* More support on the lesson.
* Keep being nice.
* Only child development can they use the google translation and work in English.
* If I learned to read write and speak, if the school can stop the boys calling us Kosovans – what is Kosova.
* This year it is better but she cant keep up because she cant read very well. If the teacher gave more help and if he explains again personally what the words are, even then they don't know what to do. It would help if someone could teach them the main points.
* I am OK.

Appendix three

Parent A – Mother of two Slovakian girls both attend secondary school, 1 pupil is year 7 and the other year 9. Both pupils have been truanting and have been involved with the EWS for sometime, Parent A has another young child who she looks after, as the father is away working for most of the day.

Parent A stated that she was happy to talk to me through the translator as she wanted to discuss the issues regarding her daughters' non attendance at school. They family have been in the UK since July 2007.

What are your views and experiences of your child/children's current education?

Parent A: I am really happy that my girls are in education I really want them to get a good education so that they can get good jobs.

Q: what have been you experiences of the current school your daughters are attending?

Parent A: Mmm I don't know, I think the school is ok, I'm not sure what else to say about it. It was the only school available to my girls when we came here, so that's where they went. I think it is too far away from our home and far away from their friends. It's very hard to send them everyday when they say "no mummy" we don't want to go.

Q: Why do you think your daughters feel this way about the school?

Parent A: I think they don't like it because of bullying, they are always coming home and saying that other children make fun of them, their accents, their clothes and I think that's all. They stay together in the school. I want them to be together so they can look after each other. Other children are not nice to them.

Q: So you feel that your daughter's school experiences have been negative.

Parent A: Yes, they have found it hard to make friends and they don't like to be there the whole day so they go and spend the afternoon in town or come home saying they are sick, not feeling well or being bullied. What can I say I have young baby to take care of, so I let them stay home.

Q: How do you feel about this situation?

Parent A: It's not good I don't think this is good for their education and not good that we are being threatened with courts and fine, this causes us a lot of stress. Along with all the other difficulties we have with schools, housing and immigration status.

What has helped you to establish a positive relationship with the school and other services?

Parent A: Umm I don't know whether anything has helped to build a relationship with the school. We find it difficult when EWS are taking court action against us. What has helped has been you coming here today and giving us an opportunity to tell you our side of the story.

When the girls first attended the school we found the support from the E2L staff helpful

Also the teacher in the learning support base who spoke Slovakian was also good.

What else do you feel would help you to feel supported by the school and professionals involved with your child's/children's education in the future?

Parent A: I think it would be helpful to keep them in school if someone would take them to school that would help. In Slovakia Police officers patrolled the streets and if they saw children who were not in school they would take them back to school. Children were more scared of the police officers so were too scared to truant, I also think more opportunities to be involved when the truanting happens not afterwards would be good.

Appendix Four

The six steps of Thematic Analysis include:

ıg friends is difficult	they have found it hard to make friends
en do not like ing the whole day at l so they truant	they don't like to be there the whole day so they go and spend the afternoon in town or come home
ıg school through :ing is not good for ducation	I don't think this is good for their education
gal consequences ıt good	not good that we are being threatened with courts and fine
ıreat of court fines is tressful	This causes us a lot of stress. Along with all the other difficulties we have with schools, housing and immigration status
ducation in the UK is	I feel that the education in the UK is much better then Slovakia
career options	there are better job prospectus
tions for the future	I think it's good that my son will be able to get a good education and

Not attending school will lead to greater difficulties/challenges	if they don't go to school they will have further problems
I don't want my son's non school attendance to result in a visit by the EWS	I don't want my son to stay at home and get EWS involved
The EWS come around and tell me my child's school attendance is poor	they come around and tell me he's not in school a
The education in the UK is much more flexible in its area of discipline	I think the education here is more lenient
In the UK you can leave school at 16	if children don't want to go to school they don't have to, when they reach 16
Some teachers expectations of Slovakian children is a concern	But there is an issue with teachers and their expectations of some children
Some subjects are challenging	my son does find some lessons difficult
Do not find all teachers to be supportive	the teachers do not help him much
Truanting lessons that are difficult to understand	he gets lost in lessons such as history and French. I know these are the lessons he truants from

The education in the UK is better than Slovakia	I think the education here is better than Slovakia
Feeling positive about the choice in moving to the UK and the educational prospects here	*I am glad my children are being educated here*
Opportunities to learn English	they get a chance to learn English
Having good English is positive	It is important to have good English
Importance is placed on being educated in the UK	*I feel it is important for my son to have a good education*
Aspirations for the children are to have more opportunities than the parents had in Slovakia	he can achieve something, something better than what we have at the moment and something better than what he would have achieved in Slovakia.
Positive opinion of the school	the school is a good school
The positive opinion of the school is also shared by friends	a lot of our friend's children go there, other Slovakian families
Chose of secondary school is influenced by other Slovakian families	That is why we chose this secondary school for those reasons.
Aspirations for the future are important, getting jobs and having a skill are important.	I would like my son also to gain a skill do some course that he can then get a job in.

Stage 3

Initial Themes

Initial Themes
Positive comments about school and Education, View school as important , The positive opinion of the school is also shared by friends, **Positive opinion of the school**
Aspirations for the future, Aspirations for the future, Hope's for the future, Going to college and getting a qualification is important, migrated here to access more opportunities and prospects for my children, Aspirations for the children are to have more opportunities than the parents had in Slovakia, Aspirations for the future are important, getting jobs and having a skill are important.
Limited choice in where their children go to school, Choice of secondary school is

influenced by other Slovakian families
Travel time to school
Being bullied, Being teased by other children for their clothes and their accent, Are treated negatively by their peers, Away from friends, Making friends is difficult
Sibling Support is important at school
Children do not like spending the whole day at school so they truant Missing school through truanting is not good for their education
The legal consequences are not good, The threat of court fines is very stressful
Not attending school will lead to greater difficulties/challenges
The education in the UK is better, The education in the UK is better than Slovakia
Better career options, Feeling positive about the choice in moving to the UK and the educational prospects here
Opportunities to learn English, Having good English is positive
Different age for compulsory schooling in the UK compared to Slovakia In the UK you can leave school at 16, Job prospectus are not good if you leave school at an early age
I don't want my son's non school attendance to result in a visit by the EWS, The EWS come around and tell me my child's school attendance is poor
The education in the UK is much more flexible in its area of discipline
Some teachers expectations of Slovakian children is a concern, Some subjects are challenging, Do not find all teachers to be supportive, Truanting lessons that are difficult to understand
Importance is placed on being educated in the UK

Stage four

Theme	Coded data
The general view regarding their children's school is positive and is influenced by members of the Slovakian community	Positive comments about school and Education, View school as important , The positive opinion of the school is also shared by friends, Positive opinion of the school, Choice of secondary school is influenced by other Slovakian families
Parents viewed the education to be important for their children's future. For positive outcomes in the future such as good jobs and qualifications	Aspirations for the future, Aspirations for the future, Hope's for the future, Going to college and getting a qualification is important, migrated here to access more opportunities and prospects for my children, Aspirations for the children are to have more opportunities than the parents had in Slovakia, Aspirations for the future are important, getting jobs and having a skill are important.
Did not feel that they had a lot of choice in which school	Limited choice in where their children go to school,

ng English is a e opportunity	Opportunities to learn English, Having good English is positive
e of school leavers is nt from that in ia	Different age for compulsory schooling in the UK compared to Slovakia In the UK you can leave school at 16, Job prospectus are not good if you leave school at an early age
ns about EWS ement	I don't want my son's non school attendance to result in a visit by the EWS, The EWS come around and tell me my child's school attendance is poor
e approach to y in schools	The education in the UK is much more flexible in its area of truancy
eaching staff are l as not supportive to eds of Slovakian n	Some teachers expectations of Slovakian children is a concern, Some subjects are challenging, Do not find all teachers to be supportive, Truanting lessons that are difficult to understand
ion in the UK is	Importance is placed on being educated in the UK

viewed as better than the UK	

Stage Five: Defining and naming the key themes

Themes	Comments/Data
Parents view of Education in the UK is generally positive and view the education system in the UK more favourably then the education system in Slovakia	The general view regarding their children's school is positive and is influenced by members of the Slovakian community The education is better here than in Slovakia Education in the UK is viewed as better than the UK Learning English is a positive opportunity
Parents viewed educations as positive for their child's future and accepted that not attending school had negative implications for their future	Parents viewed the education to be important for their children's future. For positive outcomes in the future such as good jobs and qualifications Not attending school leads to greater challenges The future opportunities are positive
Parental choice in schools was important	Did not feel that they had a lot of choice in which school their children attended
Bullying is a key issue for the young people	Bullying and teasing is a concern and making friendships is also hard
Family support is important	Having a sibling at the school is important
Truanting was viewed as negative and parents recognised the implications of their son/daughters truanting.	Truanting happens because their children do not want to be at the school for the whole day. Flexible approach to truancy in schools Parents found the legal implications of persistent truanting and found this stressful Concerns about EWS involvement
Parents did not feel that all	Some teaching staff are viewed as not supportive to the needs of

teaching staff were supportive.	Slovakian children

Stage six- Presenting the themes

What are your views and experiences of your child/children's current education?

Emerging Theme	**Qualitative Description**
Getting a good education is important	"I really want them to get a good education", "I think it's good that my son will be able to get a good education and get a good job", "I am glad my children are being educated here as they get a chance to learn English."
The education system in the UK is better than Slovakia	"I feel that the education in the UK is much better then Slovakia", "I think the education here is better than Slovakia", "The education is good here."
Bullying is an issue in my child's current school	"I think they don't like it because of bullying, they are always coming home and saying that other children make fun of them, their accents, their clothes and I think that's all", "Bullying was an issue when he first started the course."

PROFESSIONAL PRACTICE REPORT FIVE

Using Cognitive Behavioural Approaches to support the management of anxiety and to build social skills for children with Autism and Asperger's Syndrome

Abstract

Using cognitive behavioural approaches to manage anxiety related symptoms/behaviours amongst children and young people with Autism or Asperger's syndrome has become more common amongst health and educational professionals (Riat et al., 2010). This is based on a number of research studies that have identified the positive effects of CBT intervention with children and young people who have anxiety disorder symptoms (Sofronoff et al., 2005 and Sze and Wood, 2007).

The aim of this paper is to summarise the evidence base for the use of Cognitive Behavioural Therapy (CBT) with children and young people who have been given a diagnosis of Autism or Asperger's Syndrome. The rationale for this includes the author's interest and her involvement in a joint project within her local authority to support children who have a diagnosis of Asperger's Syndrome to develop positive strategies to manage anxiety provoking social situations.

The joint project involved Tier 2 Child and Adolescent Mental Health Service (CAMHS) professionals and the Educational Psychology Service. Both services aimed to support the children referred to CAMHS who were waiting to receive services including therapeutic intervention.

A six-week CBT group was based on the Exploring Feelings CBT programme by Atwood (2003), a CBT programme specifically developed for children and young people with anxiety-related difficulties and a diagnosis of Asperger's Syndrome. Parents were also involved in the intervention, through a parallel group for parents of the six participants chosen for the groups. The intervention was evaluated at the pre and post stage using a number of measures. Both parents and participants provided information regarding the effects of the intervention.

The results reported changes in children's stress and overall anxiety and parents reported some positive results regarding behaviour change across home and school. However, a six week follow up interview may have been useful to ascertain whether the intervention had an impact on a long term basis.

Cognitive Behavioural Therapy (CBT)

Cognitive Behavioural Therapy integrates the cognitive and behavioural schools of therapy. The integration of affect, behaviour, social factors, cognition and environmental influences is recognised and considered within a comprehensive intervention (Henin et al., 2003 in Simos, 2003).

The term CBT is used to cover a wide range of interventions in child and adolescent mental health contexts, including psycho-education, anger management, anxiety management, behavioural operant methods, behavioural exposure methods, self-instruction methods, graded exercise, relaxation, social skills training, parenting and cognitive restructuring (Graham , 2005, p. 9).

The theoretical underpinnings of CBT are predominately linked to the therapeutic work of Ellis (1975 and 2005) with Rational Emotive Behaviour Therapy (REBT), and Beck's (1975) work on Cognitive Therapy (CT). Ellis (2005) stated that individuals have a powerful influence over their cognitive, emotional and behavioural consequences or responses. Therefore, their beliefs can be seen as directly causing, creating and maintaining consequences or responses. REBT is concerned with an individual's rational and irrational (unhelpful and helpful) thoughts and emotions (Rait et al., 2010).

The limitations of REBT include the lack of information or exploration into how a "belief" system develops and whether there are any critical periods that relate to the developmental of irrational or unhelpful beliefs (Rait et al., 2010). Furthermore, REBT does not discuss individual differences such as internal and external risk or protective factors that children and young people have that can make a difference in how their belief systems develop (Barnes,

2000). In addition REBT requires a high level of verbal and cognitive ability and, as many children and young people's cognitive and verbal abilities vary, this makes the therapy inaccessible to some groups (Barnes, 2000).

Beck developed Cognitive Therapy and is based on the notion that psychological or behavioural problems such as anxiety and depression arise from a person's cognitive distortions. Primarily, therapies aim to work with people in a therapeutic capacity to identify and change the cognitive distortions and shift their thinking patterns about a particular situation or life event that has caused them anxiety or causes them high levels of anxiety, depression or anger. Unlike REBT, individuals are encouraged to consider how they arrived at their negative automatic thoughts.

Beck defines cognitive therapy as "the application of the cognitive model of a particular disorder with the use of a variety of techniques designed to modify the dysfunctional beliefs and faulty information-processing characteristics of each disorder" (Beck, 1993, p. 194).

The way in which dysfunctional cognitive processes are acquired, activated and subsequently effect behaviour and emotions are linked to early life experiences and parenting and these then lead on to the development of fairly fixed and rigid ways of thinking (i.e. core beliefs/schemas). New information is assessed against these core beliefs (e.g. I must be successful) and information that reinforces and maintains them is selected and filtered. Core beliefs or schemas are predominately triggered by key life events such as taking exams or going for a job interview, which lead on to a number of assumptions such as: I will only be successful if I spend all my time preparing. These assumptions lead on to automatic thoughts, which are related to the person (e.g. I must be stupid), their performance (e.g. I am not working hard enough) and future (e.g. I'll never get a job or be successful). These negative thoughts can then lead to an emotional change (anxiety or stress), behavioural changes (e.g. staying in and constantly working) and somatic changes (e.g. loss of appetite, difficulty in sleeping) (Stallard, 2003, p. 8).

Stallard (2003) suggest that the core components of CBT include the following:

- Formulation and psycho-education - education of thoughts, feelings and behaviour and the relationship between the three.

- Thought monitoring, indentifying common cognitions and patterns of thinking - focusing on core beliefs, negative automatic thoughts or dysfunctional assumptions and recording "hot assumptions".
- Identification of cognitive distortion and deficits - this provides opportunities for clients to identify common negative or dysfunctional cognitions and irrational beliefs or assumptions.
- Thought evaluation and development - this is where the identification of dysfunctional cognitive processes leads to the systematic testing and evaluation of these assumptions and beliefs and the learning of alternative cognitive skills. This leads to the cognitive restructuring where clients are able to think of different viewpoints and perspectives and look for contradictory evidence of the dysfunctional cognitions leading to more functional ones.
- Learning new cognitions - CBT programmes often involve the teaching of new cognitive skills including positive self-talk, problem solving skills and consequence thinking.
- Affective education, monitoring and management.
- Target setting and activity rescheduling.
- Behavioural experiments.
- Exposure.
- Role play and modelling.
- Reinforcement and reward.

(Stallard, 2003, pp. 8-11)

The principles of CBT have been used across a wide range of health and counselling professionals, mainly with adults and Beck's (1993) own work was predominantly with adults who suffered from depression or anxiety. Work with children and young people began to develop later, with studies such as Kendall (1994) and others, which are discussed in the section below.

Research into CBT with children and young people

There are a number of conceptual issues that come to light when discussing the application of CBT with children. The first consideration includes the lack of clarity of what exactly CBT with children consists of (Stallard 2003). For example there appears to be a lack of clarity about distinctions between behavioural interventions, cognitive behavioural interventions and specific cognitive interventions. Using CBT for childhood anxiety typically relies on education and behavioural exposure, whereas other interventions such as play or child centred therapy include relaxation training, modelling, role-playing and social re-enforcement. All of the above are often used within CBT approaches which in turn suggest that CBT for children often includes a broad range of interventions under the term CBT (Rait et al, 2010).

The second consideration when discussing the use of CBT approaches with children and young people is the use of cognitive therapy for children and the extent to which children are able to engage in and benefit from the cognitive components of the therapy. For example, their ability to distinguish between thoughts, feelings and behaviours, to make connections between all three and to identify negative automatic thoughts. Research conducted by Green and Flavell (2002) into developmental psychology suggested that from 8 years of age onwards children can engage in abstract thinking about thinking. They demonstrated that 5 year-olds, 8 year-olds and adults were able to report the specific contents of their thoughts when asked to do so. However, when asked not to have any thoughts at all for 20-25 seconds, the majority of 8 year-old children and adults reported ongoing thoughts, whereas the majority of 5 year-olds did not, suggesting that younger children have limited awareness of their own thoughts in comparison to older children and adults. Therefore, in order for CBT with children and young people to be effective it is importance to consider the developmental maturity of the children and young people it is targeted towards.

Within the literature there have also been discussions about how cognitive techniques may be adapted for use with children. Researchers such as Kendall (1990), Friedberg and McClure (2002) argued that using concrete rather than abstract language, common metaphors and practical examples from the child's daily life help younger children to engage with and understand cognitive concepts. For example, Quakley et al. (2003) suggested that the use of visual cues would enhance performance within CBT therapy. In their cross-sectional design, comparing two groups of children (aged 7 to 8 and 10 to 11) under two experimental

conditions (with or without visual cues) children within each age group were randomly allocated to socio-economic status and geographic location. They found that children with visual cues used within the CBT therapy showed a better understanding of the strategies. However, this could have also been linked to the reinforcement of the desired behaviour through visual cues.

Studies such as Kendall (1994) saw the increase of research into the treatment of anxiety disorders in children and adolescents. However, criticisms of these studies have included variations in reported effects, in their sample size and complexity of intervention programme (Cartwright-Hatton et al, 2004). Therefore, it has been difficult to distinguish between or to evaluate the level of effectiveness of CBT for this population.

Cartwright-Hatton et al. (2004) reviewed the efficacy of CBT interventions for childhood anxiety disorders. In their review they included studied of treatments of young people (under 19 years old) with diagnosed anxiety disorders such as Post Traumatic Stress Disorder (PTSD) and Obsessive Compulsive Disorder (OCD)

The systematic review by Cartwright-Hatton et al. (2004) highlighted CBT as an effective intervention for anxiety disorders of childhood and adolescence when compared to a no-treatment control. However, criticisms of Cartwright-Hatton et al.'s (2004) review include that it was sponsored by the North West NHS trust; it could be argued that the review's impartiality is questionable. Much of the research reviewed was from the United States and Australia and studies from the United Kingdom may have been useful to explore.

Other criticism of research into the effectiveness of CBT are firstly that early studies such as Weisz et al. (1995) which looked at the effectiveness of CBT, were conducted on volunteers, highlighting a weakness in the research to date, which meant that the sample did not reflect that of a possible clinical population.

Finally the research is limited with clinical populations with multiple co-morbid conditions and the evidence of the long-term effectiveness of CBT is limited. Although some studies such as Kendall (1994) and those reviewed by Cartwright-Hatton et al., (2004) highlighted that CBT is more effective then no intervention (i.e. waiting list and control groups), the

effectiveness of CBT versus other therapeutic interventions has yet to be consistently demonstrated (Rait et al., 2010).

Research into CBT and children with Autism Spectrum Disorder (ASD) and Aspergers Syndrome.

Researchers such as Atwood (2003) and Hare et al. (1997) have advocated the use of CBT with children and young people with Autism Spectrum Disorder (ASD). Atwood (2003) has suggested its use in particular, with young people who are diagnosed with Asperger's Syndrome, as a high verbal IQ generally means they are able to process logical and factual thinking. According to White (2003) children and young people with ASD whose cognitive functioning is below average are not seen as appropriate for CBT type interventions due to the nature of the intervention such as the focus on cognitive restructuring. However, it is also arguable that with adaptations to more structured CBT approaches, they can be utilised with children and young people who have learning difficulties.

According to the literature review conducted by White (2003), CBT methods can be adapted to meet the needs of children and young people with ASD by, for example, having shorter sessions, using visual methods of assessment and teaching and by using themed materials to suit the children's interests (Atwood, 2003 ; Drinkwater and Stewart, 2002).

Although only a few empirical studies have been reported on ASD and CBT interventions, these have been described as positive. These include studies such as Reaven and Hepburn's (2003), Sofronoff and Atwood (2003) and a literature review by White (2003).

White's (2003) review of published research found that there is evidence of CBT as a feasible treatment option in high-functioning children with ASD. White (2003) concluded studies that specifically defined their approach as CBT and therefore excluded studies that were using a purely behavioural approach or CBT as part of a multifaceted intervention program.White (2003) reviewed controlled studies and case studies with more than five participants. Sofronoff and Atwood (2003) undertook a randomised controlled trial, Vickers (2003) and Reaven and Hepburn (2003) did case studies with less than five participants.

Sofronoff and Atwood's (2002) study included 65 children aged 10 to 12 with a diagnosis of Asperger's Syndrome. Children with co-morbid diagnosis, such as Attention Deficit Hyperactivity Disorder (ADHD), were included in the trial. Children were randomly assigned to three treatment groups, a CBT group (24 participants), CBT involving parents as co-therapists (27 participants), or a waiting list control group (14 participants). Children received CBT treatment in groups of three over two-hour sessions per week over a period of six weeks. In the CBT with parents as co-therapists group the parents worked through the programme while their children received the CBT intervention.

Outcomes were measured pre, post and at a 6-week post intervention follow up. The main outcome measure used was the children's ability to offer solutions to a hypothetical anxiety-provoking situation (The James and the Maths Test, a problem-solving scenario based evaluation tool) and parent's perceptions on the behaviours related to Asperger's Syndrome, which was not further defined in the study. Parents were asked to identify which of 15 behaviours had occurred over a two week period and how they rated their ability on a scale of 1-5 in managing this behaviour.

The results highlighted that CBT both with and without parents as co-therapists significantly increased the number of positive solutions the child was able to provide to the "James and the maths test" scenario post intervention and at the six week follow up assessment. Also both groups (with and without parents as co-therapists) significantly improved parents' self-reported efficacy in managing behaviour compared with the waiting list control group. As neither of these outcomes were validated the clinical importance of these results is unclear.

Criticisms of Sofronoff and Atwood (2003) included that much of the results were based on parents' self-reports regarding managing children's behaviour. The children's results were based on the number of positive solutions young people were able to identify at the post and follow up stage of the intervention. This does not necessarily give a clear indication of the impact of the CBT on the children cognitive processes or the long term impact of the treatment. As generalisation of a new skill is often difficult for children with Asperger's Syndrome, this may have impacted on the extent to which the young people in this study were able to generalise their learning to their real life situations. No qualitative information was presented in this study so this is also highlighted as a criticism as the views of how the intervention helped the participants directly may have been useful to the overall results.

Reaven and Hepburn (2003) conducted a case study using CBT to treat Obsessive Compulsive Disorder (OCD). They discussed the results of a female aged 7. An independent examiner administered the Autism Diagnostic Interview schedule (Lord et al., 1994) with the parent and this identified that the female met the criteria for Asperger's Syndrome. Her specific symptoms included a lack of social interaction with peers, difficulties in social communication and poor social skills but she was described as bright and had good expressive and receptive language skills.

Pre-intervention assessments included the administering of the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) by Goodman et al., (1989a) in a joint interview with the child and her mother. The intervention focused on reducing the child's OCD symptoms and not her obsessional interests linked to her ASD. A CBT programme was modified to incorporate strategies that would support the child's difficulties that were linked to ASD. The CY-BOCS was re-administered to the participant and her mother at the post intervention assessment. The participant received a score of 8 on the CY-BOCS scale post intervention, compared to her initial score of 23 suggesting a 65% decrease in her OCD symptoms over a 14-week period of intervention. A four-week follow up reported positive outcomes for the participant as both her and her mother reported that the OCD symptoms were much more manageable and she was able to apply the tools and strategies' that were encouraged during the intervention.

The results from this case study suggested that a modified CBT programme could be effective in decreasing OCD symptoms in children with a diagnosis of Asperger's Syndrome. These findings, however, are limited in the generalisations due to the single case study design. Also, the effects of the participant's individual characteristics, motivation, family and environmental factors are not clear and could have had an impact on the overall outcome. The affects of the OCD medication could have also impacted on the results. These uncontrollable variables mean that that it is unclear to what extent the CBT treatment impacted on the decrease in symptoms. Even with the above weaknesses this case study does provide a way forward in further discussions regarding anxiety disorders with children with an Autistic Spectrum Disorder-Aspergers Syndrome.

Sofronoff et al. (2005) researched the use of a CBT programme to reduce anxiety with children who were diagnosed with Asperger's Syndrome. They used strategies' developed to

support children with an Autism Spectrum Disorder that have been used with some success with this population such as social stories (Gray, 2000) and comic strip conversations (Gray, 1994) and a CBT theoretical framework "Exploring Feelings" by Atwood (2003).

In this study all participants had a primary diagnosis of ASD by a paediatrician and initial assessments were completed via phone interviews with the parents that included the administering of the Childhood Asperger's Syndrome Test with items based on the DSM-IV criteria (CAST, 2002; Scott et al., 2002).

Child anxiety was measured through parent reports at the initial phone interviews stage. Families were then randomly assigned to either intervention 1 (child only), intervention 2 (child and parent) and the wait list (control group). Groups included three participants, two therapists, 45 children participated in the study. The results suggested that in parent reports of child anxiety, parents reported fewer instances of anxious symptoms at the six week follow up. Furthermore, the child and parents group showed significant improvements in the children's anxiety symptoms when compared with the child only group.

Sofronoff et al. (2005) also assessed the child's understanding of the interventions tools and strategies' using a hypothetical scenario-based evaluation. They found that post intervention children were able to generate more strategies' in how to deal with an anxiety provoking situation at school. The most strategies identified were from the combined child-parent group. Qualitative findings, such as descriptions provided by parents about the change they observed in their child, indicated that many children from the combined group had now developed friendships. Some parents also noted that their children seemed more confident in their day-to-day interactions suggesting that the time spent with children similar to themselves had helped in their overall confidence.

The limitations or weaknesses of the study include the small sample size (45) and the largely parental reports that were used to obtain results. The parental expectations of the interventions could have been a factor in their overall perceptions regarding the success of the group. Multiple sources of data, such as information from the school could have provided further analysis data on whether the CBT intervention had affected the participants overall behaviours in the school environment. Also a comparable parent only group would have provided evidence about the parental expectations and anxieties that could have impacted on

the overall intervention process. Furthermore, there was no formal qualitative information reported and the informal qualitative feedback was again from the parent's perspective. A parental only group would have helped to eliminate any parental anxiety and expectations that may have impacted on the results obtained.

Sze and Wood's article (2007) described the successful treatment of an 11-year-old girl (Sophie) with high functioning autism (HFA and co-morbid anxiety disorder) and her mother using a manual-based family cognitive behavioural therapy (FCBT) intervention, which was adapted for children with ASD. The programme is described in the Sze and Wood (2007) study as an adaptation and flexible program based on the "building confidence" program (for more information on the adapted CBT program see p. 135, Sze and Wood, 2007).

The pre intervention measures used included the Anxiety Disorders Interview Schedule (DSM-IV- 2000), parent and child versions (ADIS-C/P, Silverman and Albano, 1996). These were used in semi-structured interviews with both Sophie and her mother to ascertain her levels of anxiety and general social skills. Sophie was described as having generalised anxiety disorder (GAD) and some social behavioural difficulties at school. Information from the school was not obtained so much of the pre-intervention information was parent reports.

The treatment consisted of sixteen 90 minute FCBT sessions over the course of four months. At post treatment the same ADIS-C/P were used to gain information. The results suggested that Sophie no longer met the criteria for GAD. Sophie's mother also reported that Sophie no longer experienced anxiety around school work and the weather, which were highlighted as a concern at pre-intervention. The parent report also stated "superior satisfaction" with the treatment for Sophie.

The case study by Sze and Wood (2007) reports positive results for FCBT intervention with a child who was diagnosed on the Autism Spectrum, but there is no information available from the perspective of the school context and the positive comments reported were obtained from parental reports. Also, individual characteristics of Sophie such as motivation and personal interest (used in the sessions) could have been contributing factors. Parental active involvement could have also been another contributing factor to Sophie's ability to acquire the CBT concepts during the intervention as homework based activities and consistency is

important to ensure success of any intervention particularly for children who have both ASD and anxiety disorders (Reaven and Hepburn, 2003 and 2006 and Sofronoff et al., 2005).

Criticisms of Sze and Wood (2007) include the case study design, as this limits the possibility of generalisations to wider populations and from the results obtained it is unclear to what extent the results were a consequence of the level of engagement with the intervention and how the level of parental engagement impacted on the parents perception of the treatment outcomes.

Wood et al. (2009) conducted a randomised controlled study of forty children aged between 7-11 years who were diagnosed with ASD with their primary care givers. Therapists worked with families for 16 weekly sessions, each lasting 90 minutes, divided into 30 minutes with the child and 60 minutes with the parents/family. They adapted a version of the "Building Confidence" CBT program by Wood and McLeod, (2008). They adapted this to meet the communication difficulties associated with ASD as suggested by Atwood (2003 and 2004). Pre and post measures were administered by independent evaluators who were blind to the intervention of each family. Each individual child and care giver was interviewed using the Anxiety Disorders Interview Schedule for DSM-IV (ADIS-C/P, DSM-IV 2000). The interviewer/evaluators made ratings on a Clinical Severity Rating scale (CSR) where 0 was not at all, 4 was some and 8 was very much on evidence of the problem behaviour. The Multidimensional Anxiety Scale for Children (MASC, 1996) and the parallel parent report version by Wood et al., (2006) were also administered to the treatment group and waitlist group.

The results highlighted that 13 out of 14 of the treatment groups responded positively to the treatment compared to only 2 of the 22 children in the controlled conditions. Nine of the 14 intervention group participants no longer met the anxiety diagnosis criteria and 2 of the 22 control group participants. For the parent-report MASC scores there was a statistical significant difference between the intervention group and the control group. The results from this study offers support for the efficacy of an enhanced CBT program for children with ASD and co-morbid anxiety disorders as children randomised to the CBT intervention had primary outcomes comparable to those of typically developing children who were not diagnosed with ASD.

The limitations of the study included the MASC self-report measure (child version) that did not yield significant results for this study. This could have been because the self-report measure may not have been a suitable measure for ASD populations, as difficulties associated with ASD may have led to the participant's interpretation of the self report measure to have affected the overall results. Although a control group was used, the main difference identified was that 9 out of the 14 intervention group's participants did not meet the criteria for anxiety diagnosis post intervention. However, it is unclear to what extent the anxiety at the pre-assessment was linked to ASD characteristics or to generalised anxiety, as many ASD children would find situations such as a pre-assessment anxiety provoking, more so then at post assessment.

Overall, it can be argued that much of the research regarding CBT interventions with children and young people with a diagnosis of ASD or Asperger's Syndrome are quantitative in their methodology. There appears to be lack of qualitative information and this can be argued as a weakness of the overall research in this area. Using a mixed method approach could have enhanced the qualitative findings particularly as results from the participants perspective is lacking. Studies which have used some qualitative data have been predominately parental reports.

Also, sample sizes of the research remained small, as they were either a single case study design or relatively small groups of participants in randomised controlled trials. No information is provided regarding cultural variations in samples nor has the impact of medication been addressed in the overall research design in many of the studies identified above. Furthermore, the lack of data from schools is also highlighted as a weakness of the research in this area. As many children with ASD or Asperger's Syndrome find school environments challenging and anxiety-provoking, information regarding levels of anxiety at school pre and post intervention may have identified whether the interventions had impacted on the participants school related anxiety.

Finally the research can be criticised, as the results of many of the studies appear to focus predominantly on behavioural change as outcome measures, such as reduced anxiety or parental perceptions of behaviour management. This raises questions regarding the level of cognitive restructuring during the CBT intervention. Further research could focus on changes

in cognitive processes in order for the results to address the key aims of CBT, which include the cognitive restructuring and the shift from negative thinking processes to positive.

Background to the Intervention

This section discusses the work of the Educational Psychology Service within a South East Local Authority (LA) in collaboration with the Child and Adolescent Mental Health Services (CAMHS) Tier 2 services. The joint project aimed to reduce the lengthy waiting lists of the Tier 2 services for children and young people within the local area who were diagnosed with Autism or Aspergers Syndrome.

Many young people in the local area who had a diagnosis of Asperger's Syndrome, who were also experiencing high levels of anxiety and exhibiting difficult behaviour at home and at school, were referred to Tier 2 services to access individual or small group support through therapeutic intervention. However, due to long waiting lists, families were not able to access this support for an average of 7-8 months waiting time.

The professionals working at Tier 2 included a primary mental health worker and a part time clinical psychologist who were unable to offer any group work to children and parents, as this would require time and resources that they did not have. A discussion with the Senior Educational Psychologist based in the LA Educational Psychology service led to the development of a joint social skills group with the support of the author, an EP and both Tier 2 professionals. The aim of the intervention was to provide support and positive strategies to manage difficult social or anxiety provoking situations.

The Tier 2 professionals had both previously used the CBT Exploring Feelings for Anxiety and Anger program by Tony Atwood (2003). The aim of this program is to support children and young people with Asperger's Syndrome who have specific difficulties with social communication and interaction. For example, they have limitations in recognising and understanding of emotions and have considerable difficulty identifying and conceptualising the thoughts and feelings of themselves and others. The CBT program focuses on aspects of cognitive deficiency in terms of levels of maturity, complexity and efficacy of thinking about emotions and cognitive distortion in respect of dysfunctional thinking and incorrect

assumptions. Thus, it can have a direct applicability to children who have Asperger's Syndrome. Cognitive deficits could include limitations in the expression of emotions, limited vocabulary for many emotions and difficulty in controlling these emotions and misunderstanding of others' intentions particularly in social situations.

CBT with children and adults with Asperger's Syndrome has several stages (Atwood, 2003, p 3):

- Affective education where participants learn about emotions, their use, recognising them and at different levels. Connecting cognition, feeling and behaviour.

- Cognitive restructuring, which includes targeting negative thoughts and dysfunctional beliefs. The participants are encouraged to examine the evidence for and against their thoughts or emotions and create alternative perceptions of a specific event.

This CBT program also recommends the use of a parents group (Atwood and Sofronoff, 2003), which can run simultaneously with the children's group. The aim of the parents group is to discuss the work the children are doing in their group and how parents can support their child to use the strategies learnt in the group to generalise into real life situations and to support children with the homework tasks, another important aspects of CBT approaches.

For details of the session plan for both the children and parents groups please see Appendix 1. Sessions were one hour long and ran for six weeks.

Participants

Six children were identified from the Tier 2 waiting list. All the children had a diagnosis of Asperger's Syndrome, children who had a co-morbid diagnosis such as ADHD and OCD were not included. Children who were taking medication were included in the study because many of the children on the waiting list were on medication so excluding them would have left one or two children (not enough to run a group). The children who were on medication created an uncontrolled variable, which meant the pre-assessment interview information regarding the use of medication, would be required.

The participants were between 11 and 12 years old, four of whom were still in a primary school and two were year 7 pupils in a secondary school. There were five boys in the group and one girl. All children and their parents/carers were invited for an initial assessment. The aim of the assessment was to assess the young people's suitability for the groups and their general level of motivation to engage with the process.

Method

The aim of the intervention was to support young people with Asperger's Syndrome with anxiety around social situations and to support them to find positive strategies to deal with difficult peer interactions and situations that caused them anxiety.

The overall epistemological stance for which the methodology was based on can be viewed as Critical Realism. Critical Realist's, who are described within post positivist philosophy, argue that all observations are fallible and have a degree of error and that all theory is revisable. This means that the critical realist is critical of researchers' ability to know reality with certainty (Cohen and Manion, 2007). Therefore, taking a Critical Realist epistemological viewpoint, all measurements in this study are viewed as fallible and it is viewed as important to ensure multiple measures and observations are conducted to triangulate the results across these multiple error sources to gain a better understanding of what's happening in reality.

The overall research design adopted by the professionals in this evaluation was a mixed method. Both quantitative and qualitative data collections processes were used and information was obtained from both parents and participants to ensure the data sources where triangulated.

The quantitative and qualitative data collection methods were questionnaires and semi-structured interviews. There are a number of advantages and disadvantages to using questionnaires to gather data. These include:

Advantages:

- More data can be collected from a larger sample.
- People are used to completing paper-and-pencil surveys so would not find this as intrusive as other methods.
- Respondents can take the survey with them and complete it anywhere and at any time.
- The nature of surveys can work well for gathering information on sensitive issues.

The disadvantages include:

- One of the main criticisms of questionnaires is that they are restrictive in nature. The fixed response questions are limited in richness of data therefore it is useful to triangulate this data with semi-structured interviews.
- Participants need to be motivated to return the questionnaire and see the importance of responding promptly
- Respondents must be able to read, see and write.

(Cohen and Manion, p. 25, 2007)

Semi-structured interviews were also used as a method of data collection as the researchers wanted to gain a richer and deeper perspective from both the parents and the young people participating in the intervention. This process allowed for the researchers to discuss participant's expectations and goals for the intervention and use this as a basis for post intervention discussion. It also provided the researchers with the opportunity to gain more insight into some of the questions answered by the participants in the questionnaire. However, the researchers were also aware that semi-structured interviews can often create a bias towards the researcher, and participants may have not been entirely honest in their views about the intervention at the post-intervention interview as the interviewers were also the professionals who organised and delivered the intervention.

Measures

At the initial assessment and interview stage the parents/carers and the participants were given a series of questionnaires (SDQ's and TRMF's) to complete to help gather some baseline information. The interviewers (the two Tier 2 professionals from CAHMS, TEP and EP) interviewed families and discussed their goals and expectations of the groups using a goal attainment-scaling questionnaire (TRMFS, Appendix 2), a tool used within the EPS to evaluate the outcomes of casework/group work they complete (Monsen et al., 2009)

Both parents and participants were asked to complete a strengths and difficulties questionnaire (SDQ, Goodman, 1997 and 2001) (see Appendix 3). These questionnaires

aimed to gather information on the degree of difficulties young people had in peer relationships, hyperactivity, level of emotional response to particular situations and their pro-social behaviours.

Finally professionals carrying out this study thought that information from the school context would be a useful indicator for assessing whether the intervention was impacting on the young people's anxieties and emotions in the school environment. Therefore, a SDQ teacher report was sent pre and post assessment. This measure can be criticised. Although it has some evidence to support its validity and test-retest reliability, criticisms regarding these studies have shown that the reliability of SDQs are limited, due to the small sample sizes used (Goodman, 1999)

Results

The results were based on pre-assessments conducted two weeks before the start of the intervention and post-intervention assessments were conducted two weeks after the intervention. Although a follow-up of the post-intervention assessment would have been highly valued and desired by the researchers, due to time constraints in the Educational Psychology Service and for the CAMHS Tier 2 professionals, this was not possible. The assessments included interviews with parents/carers who attended the groups and the two measures of Strengths and Difficulties Questionnaire (SDQ) and Target Review and Monitoring Form (TRMF, Monsen et al., 2009) (see Appendix 2 for a copy of the educational psychology service TRMF evaluation form).

Figure 1 below is a summary of the TRMF data obtained from joint interviews with parents and participants. The table provides a summary of the goals set by parents regarding what they hoped to achieve from the groups and their baseline, expected and actual ratings from a scale of 1 to 10. The qualitative information was obtained using solution-focused type questioning. Both parents and young people were able to identify at least one goal that they hoped to achieve from their participation in the intervention. This provided a post intervention discussion regarding whether or not they felt the group intervention had been successful for them in achieving their goal. It also allowed for the parents and pupils to reflect on what they

had taken from the group intervention and hoped to continue to use after their attendance in the group.

- Pupil A (male aged 11 years) who attended all six sessions with his mother:

    1. Goal: to stop losing my temper (set by pupil).
    2. Goal: to express emotions for example tell mum when he is sad, upset, angry (set by mother).

- Pupil B (male aged 11 years) who attended all six sessions with his mother:

    1. Goals: to find a better way of dealing with his anxiety (set by mother).
    2. Goal: to make friends who have Asperger's related difficulties (set by pupil).

- Pupil C (female aged 11 years old) attended all six sessions with her mother:

    1. Goal: to make friends with peers who have similar difficulties (set by pupil).
    2. Goal: to be able to talk more about and express how she is feeling (set by mother).

- Pupil D (male aged 12 years) attended all six sessions with his mother:

    1. Goal: to express and manage emotions in a better way (set by pupil).
    2. Goal: get a better understanding of Asperger's Syndrome and understand the Asperger's view of the world (set by mother).

- Pupil E (male aged 11 years) attended all six sessions with his mother and father:

    1. Goal: to stand up for himself and be more confident (set by pupil).

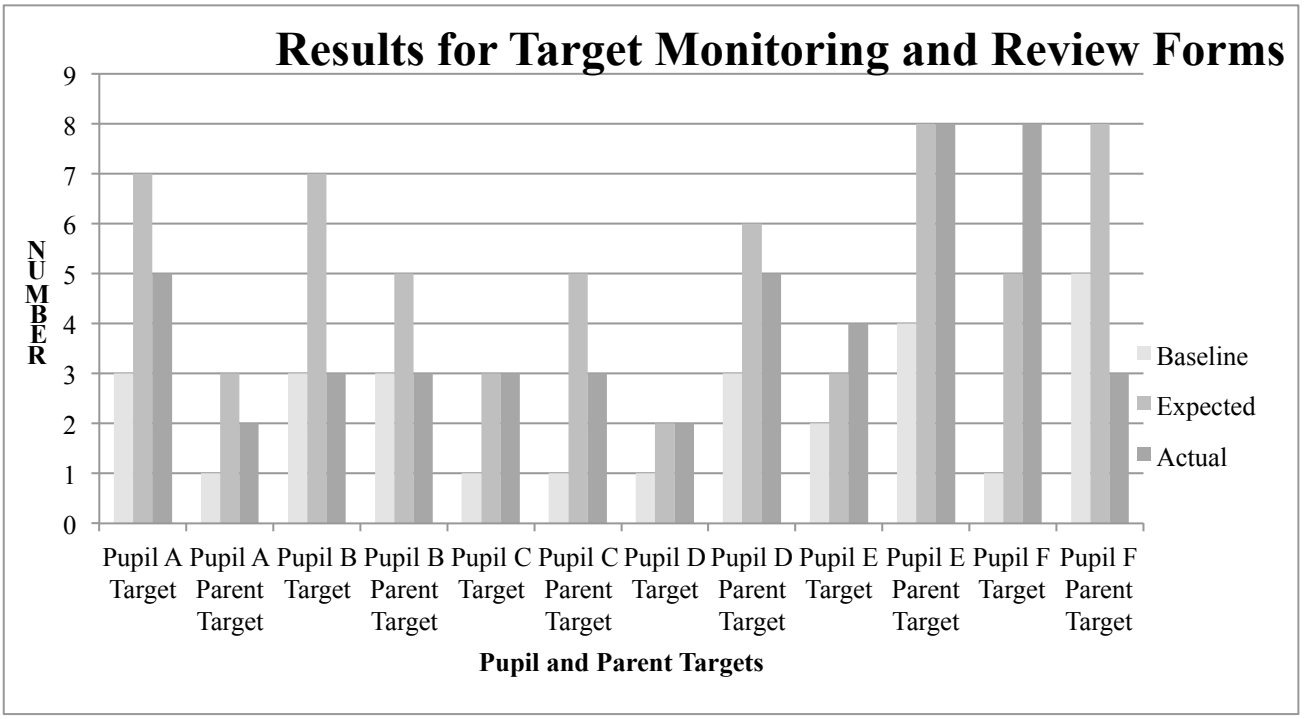
2. Goal: to learn more about Asperger's Syndrome (set by mother).

- Pupil F (male aged 11 years) attended five sessions with his mother:

1. Goal: to be able to find a positive way of managing sibling conflict (set by pupil).

2. Goal: to be more co-operative and listen to instructions (set by mother).

Figure 1: results for the TMRFs



The scores for baseline, expected and actual outcomes suggested that many of the parents and pupils expected outcomes were higher than the actual targets they felt were achieved in relation to the goals they had set. For example pupil A expected to achieve a number 7 on the scale for his goal of "to stop losing my temper" (where 0 was cannot stop losing my temper at all and 10 was I ' am completely in control of my temper and never loose my calm). He had seen himself as 3 on the scale before the intervention (baseline) but post intervention had felt that he had moved up to a number 5 on the scale. This suggested that there had been a small shift towards achieving his goal after attending the group intervention.

Both pupil E and pupil F had perceived themselves as having exceeded their expected target. Their actual goal ratings were higher than their perceived goal ratings. Both pupils had set specific targets linked to social situations that, pre-intervention, caused them stress and anxiety. Both pupils stated at the post intervention stage that they were now able to use strategies from the group to help manage these particular social situations. Pupil E's parent

had also felt that her actual target met her expected one. Her goal was to "learn more about Asperger's". As the parents group focused heavily around this, her actual target reflected this.

Out of all the parents and participants who took part in this evaluation (12) all but three people had either exceeded, met or had made some movements towards their expected target or goal. Pupil F's mother had perceived the situation to have become worse since the pre assessment stage as her actual target was lower than her baseline and expected score.

SDQ pre and post intervention results

The SDQs were scored for pupils, parents and teacher responses. The questionnaire measured six areas of social, emotional and behavioural difficulties. The codes used to report the results are identified below. The scores obtained pre and post interventions and are highlighted in the graphs below pupil, parent and teacher responses.

Questionnaire Category Key: Stress = **S**, Emotional Distress = **ED**, Behavioural Difficulties = **BD**, Hyperactivity and Attention Difficulties = **HAD**, difficulties in Getting Along with other Young People = **GAYP** and Kind and Helpful Behaviour = **KHB**

Pupil responses to SDQs, pre and post intervention

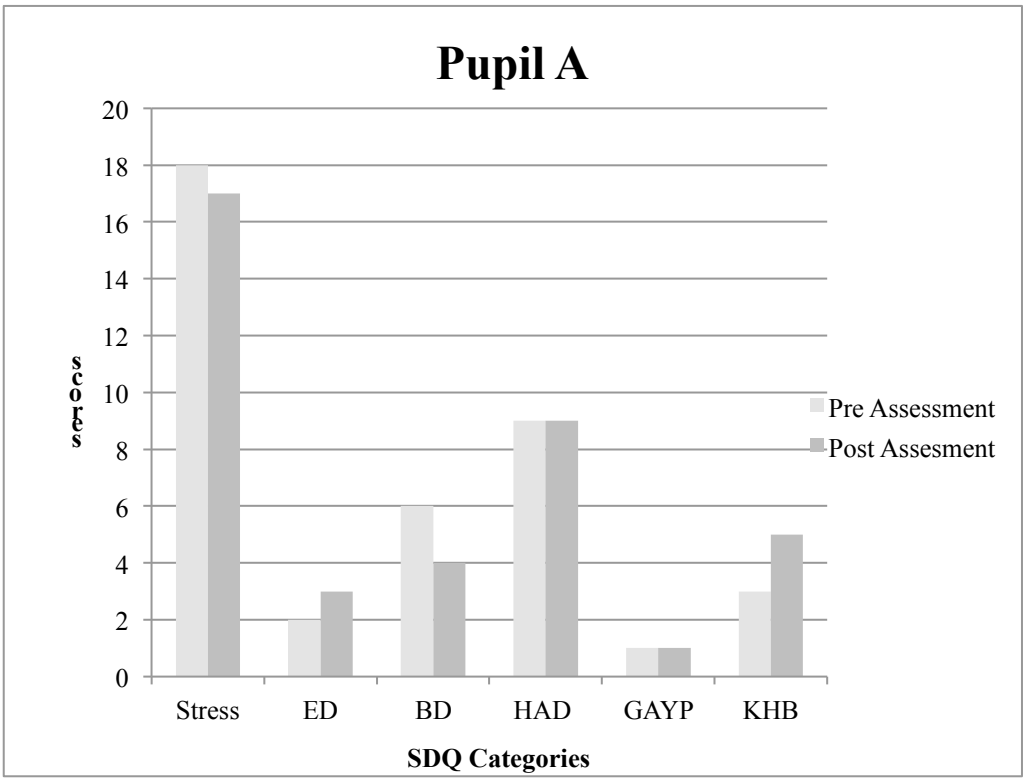


Figure 2: the pupil self reports on the SDQ highlighted that for pupil A there was an overall reduction in the Stress (S) and Behavioural Difficulties (BD) categories. However, the Hyperactivity and Attention Difficulties (HAD) categories did not show any movement in the pre and post scores.

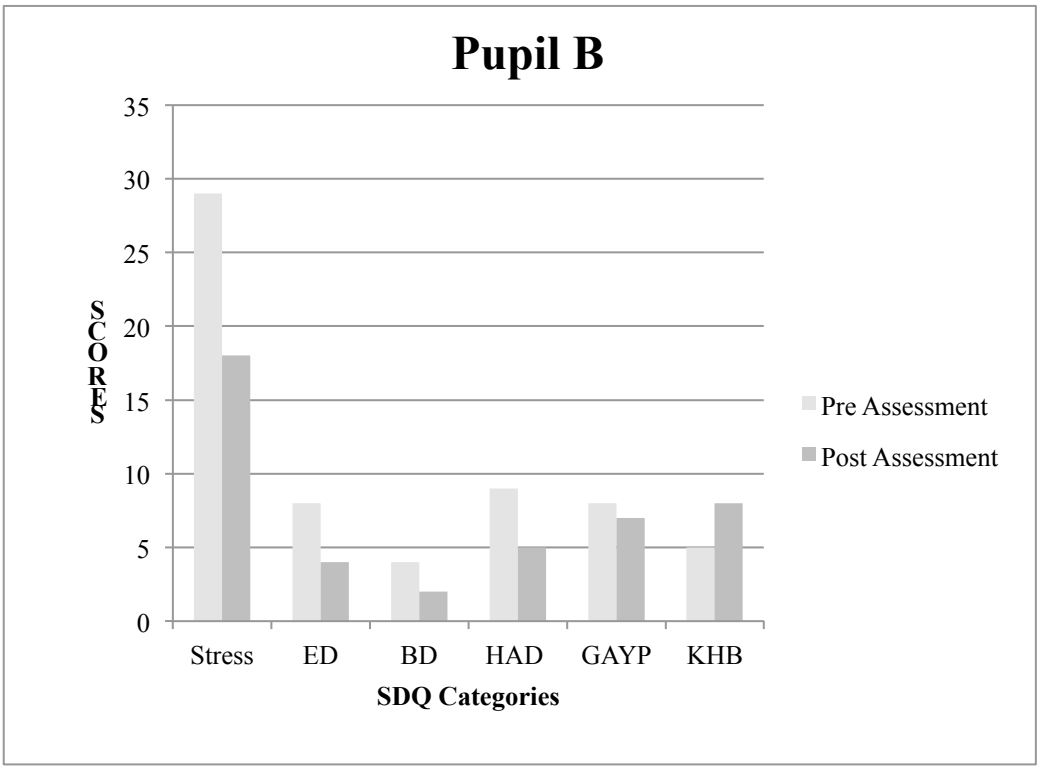


Figure 3: for pupil B there was a decrease in all but one category of the SDQ questionnaire. The Kind and Helpful Behaviour score (KHB) remained relatively the same at the pre and post intervention assessment.

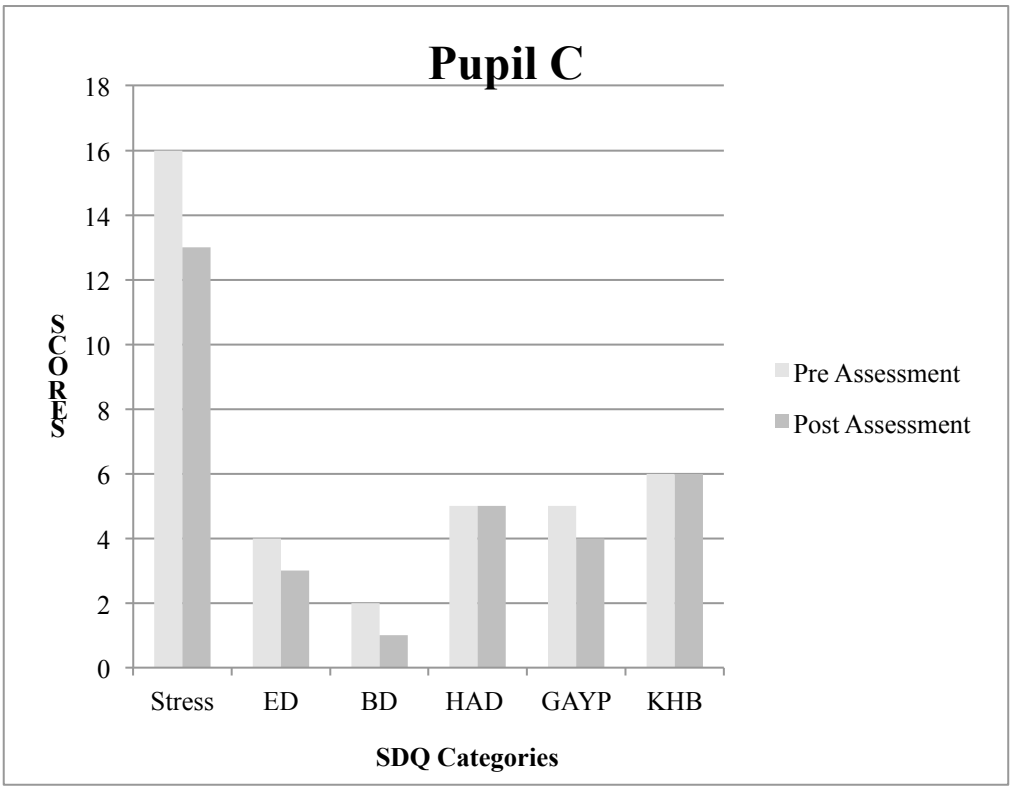


Figure 4: for pupil C scores for Stress had decreased from slightly raised to close to average. Scores for other categories did not show any change in responses from the pre intervention assessment.

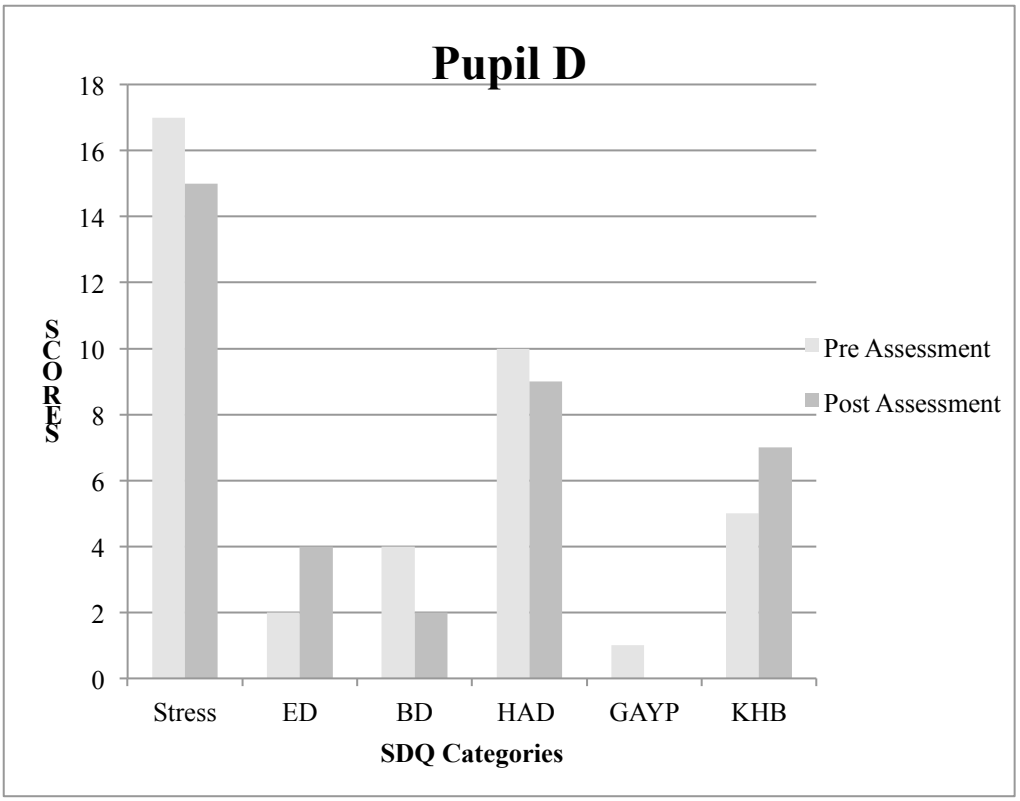


Figure 5: pupil D also reported a decrease in Stress related difficulties in the post SDQ and an increase in Kind and Helpful Behaviours.

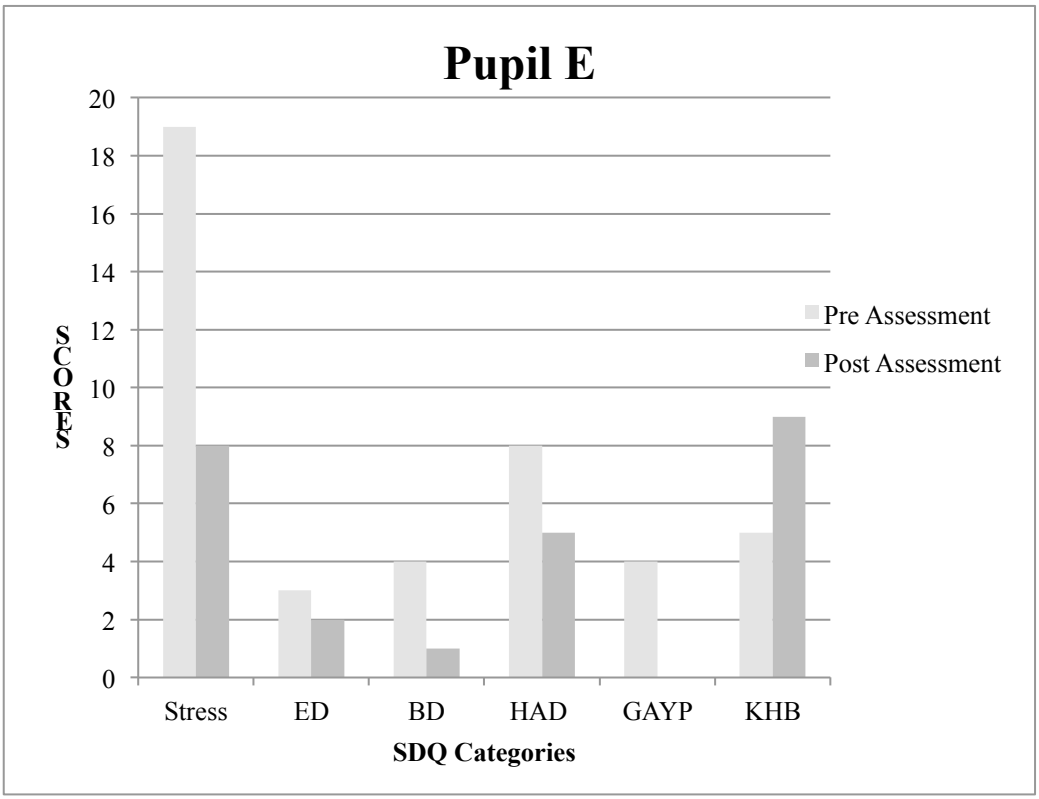


Figure 6: pupil E showed a decrease in his self-report for Stress, Behavioural Difficulties, Hyperactivity and Attention Difficulties and an increase in Kind and Helpful Behaviour.

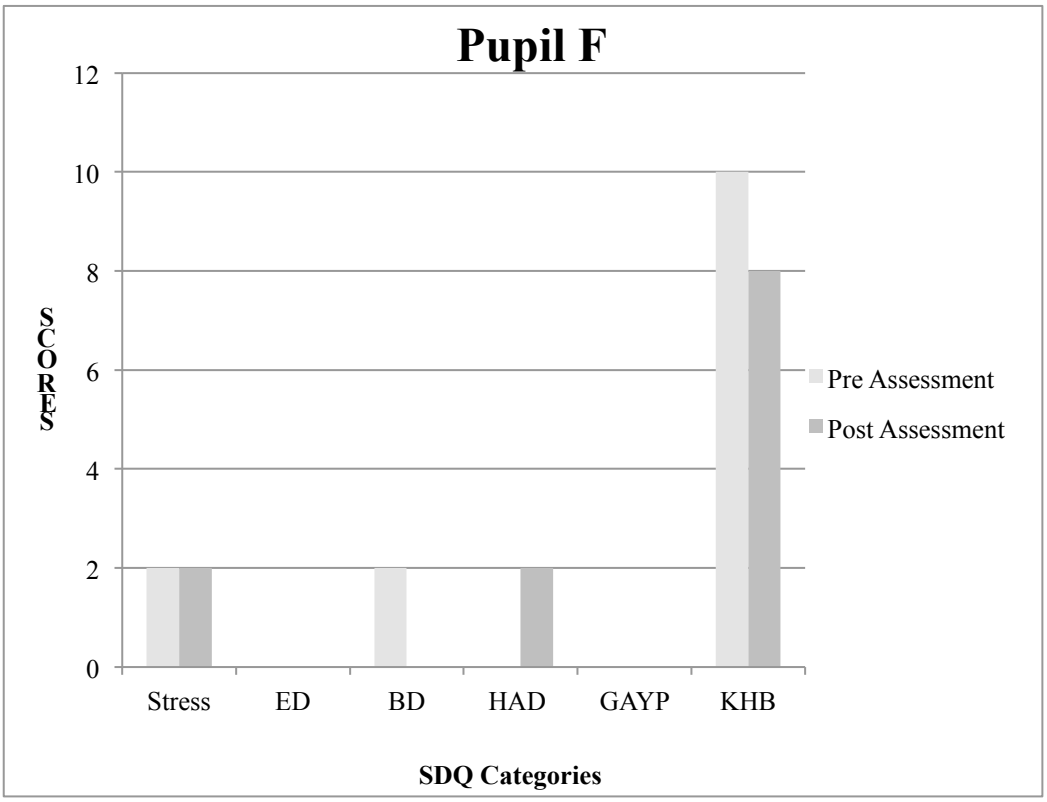


Figure 7: finally, pupil F's self-report pre and post intervention remained within the close to average range for all six categories.

Parent SDQ responses, pre and post intervention

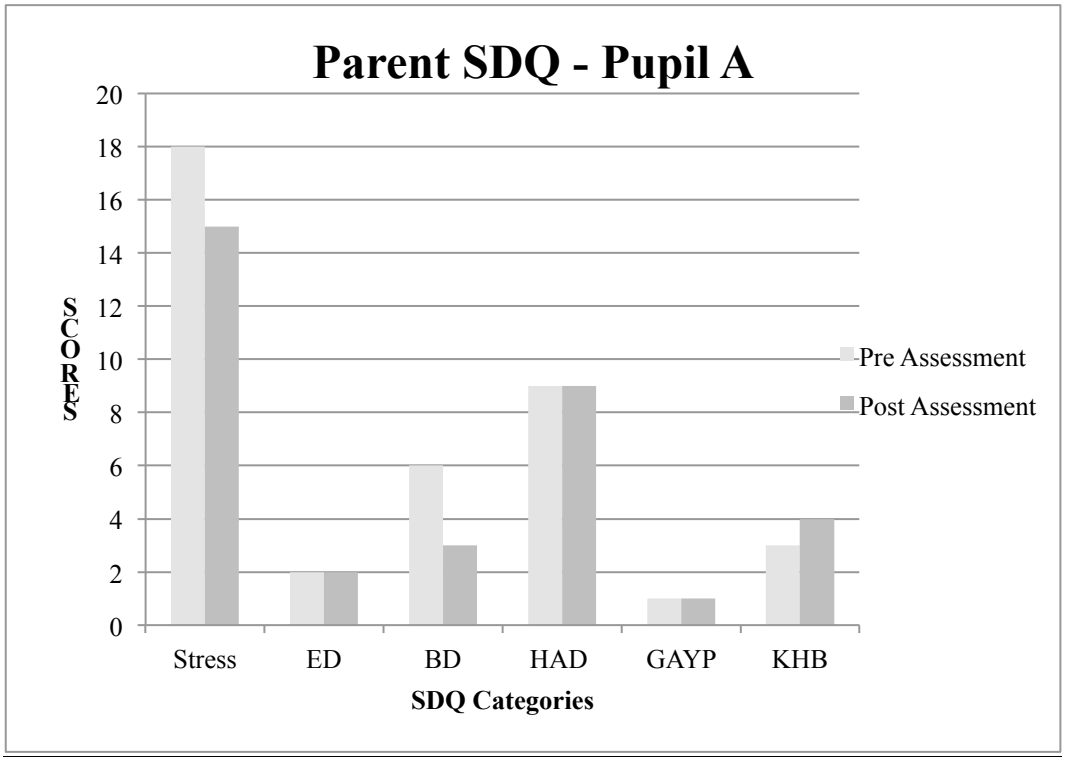


Figure 8: pupil A's mother identified a decrease in Stress and Behavioural Difficulties post intervention. Other categories appeared to remain the same pre and post intervention. Pupil A's mother also reported an increase in Kind and Helpful Behaviour (KHB) post intervention.

Figure 9: pupil B's parent identified a decrease in five SDQ categories and an increase in the KHB category.

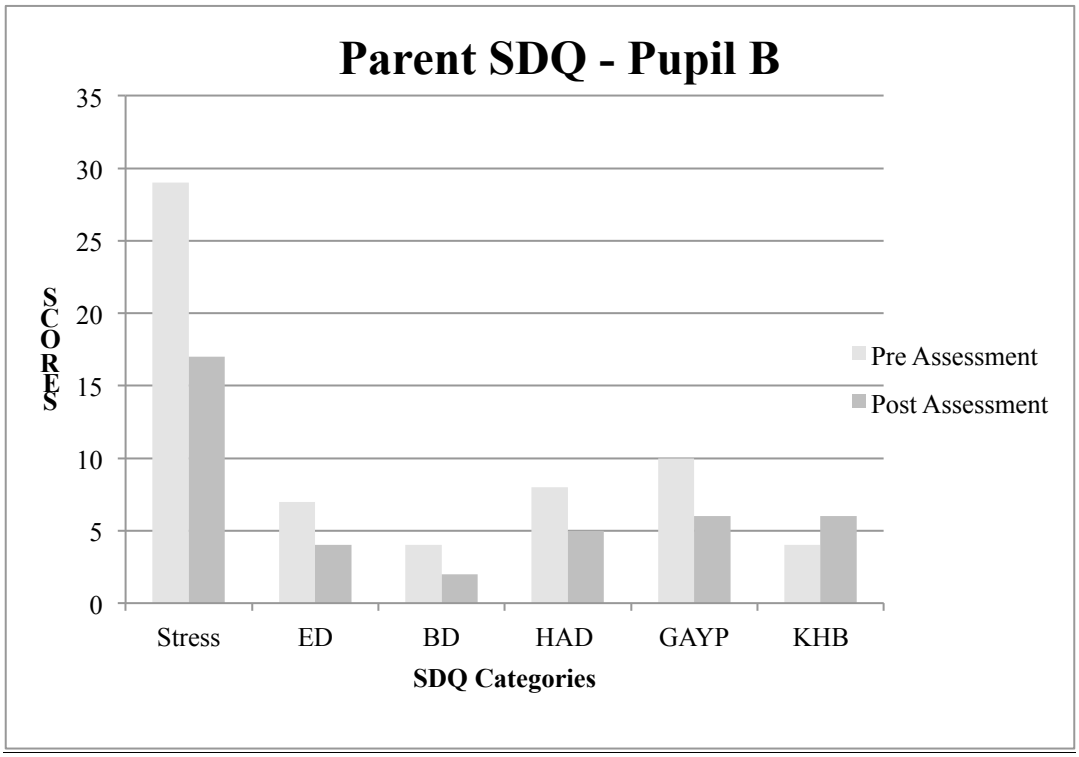
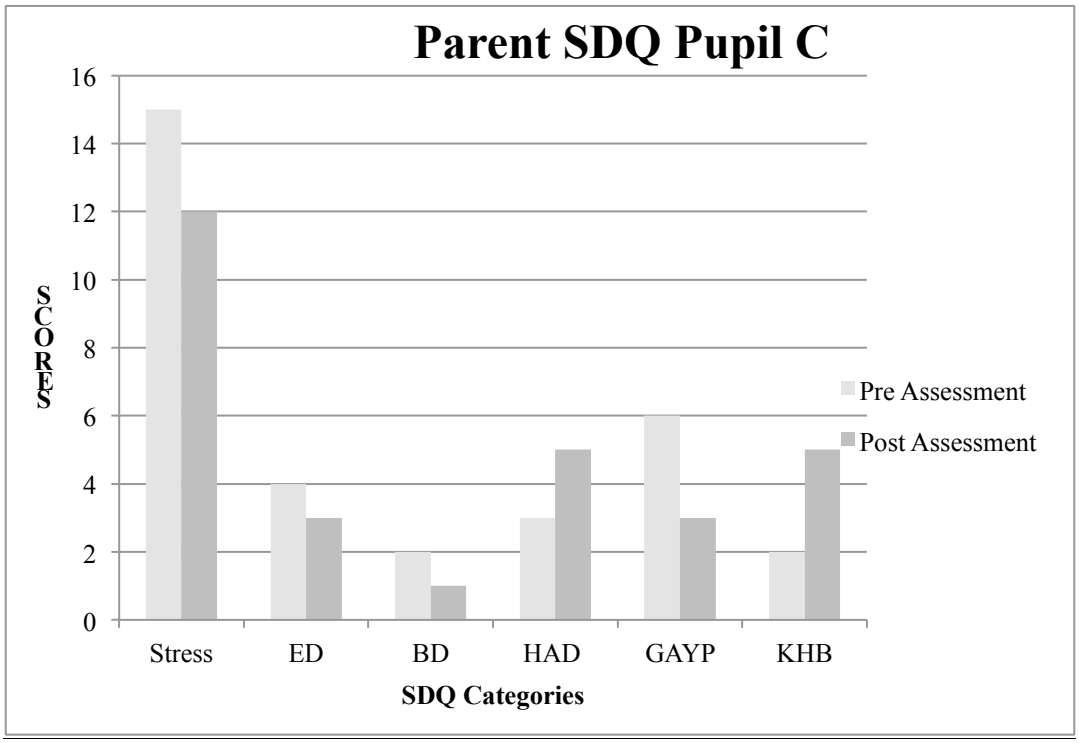


Figure 10: for pupil C, the SDQ reports from the parent highlighted a decrease in Stress, ED, BD and GAYP but an increase in Hyperactive and Attention Difficulties (HAD)



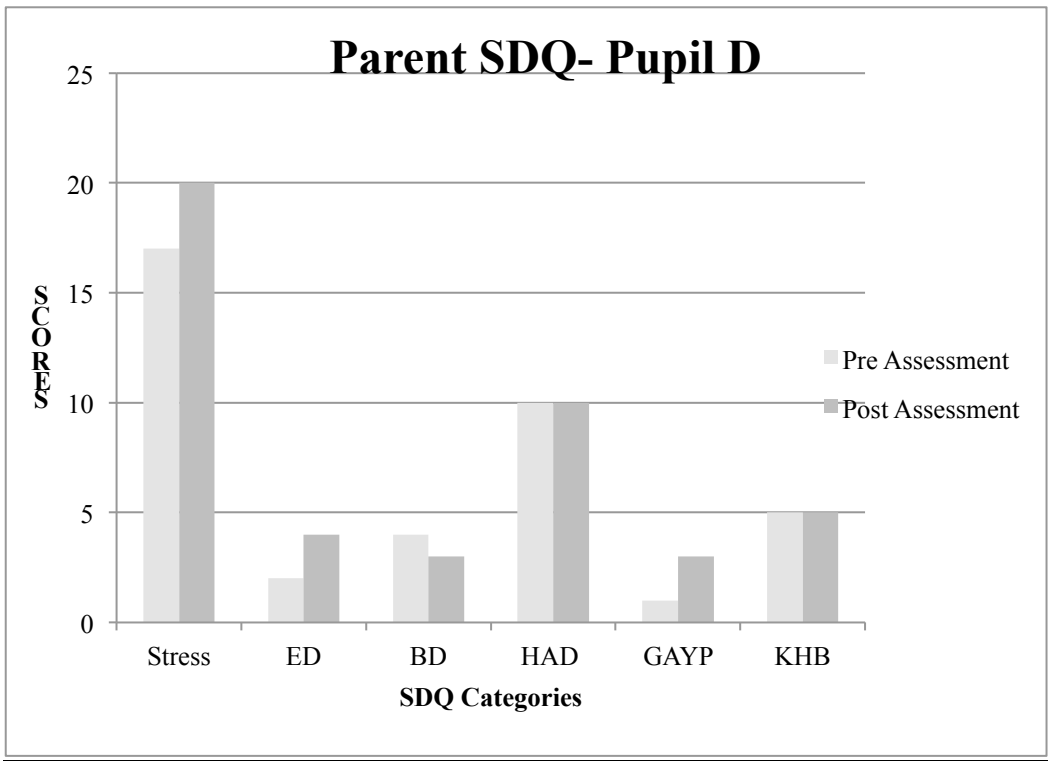


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Figure 11: for pupil D's mother, the post assessment results highlighted an increase in Stress, Emotional Difficulties (ED) and difficulties in Getting Along with other Young People (GAYP), a decrease in BD and both KHB and HAD remained the same. It should be noted

that during the six-week intervention pupil D's grandmother passed away, which could have impacted on the scores at the post assessment.

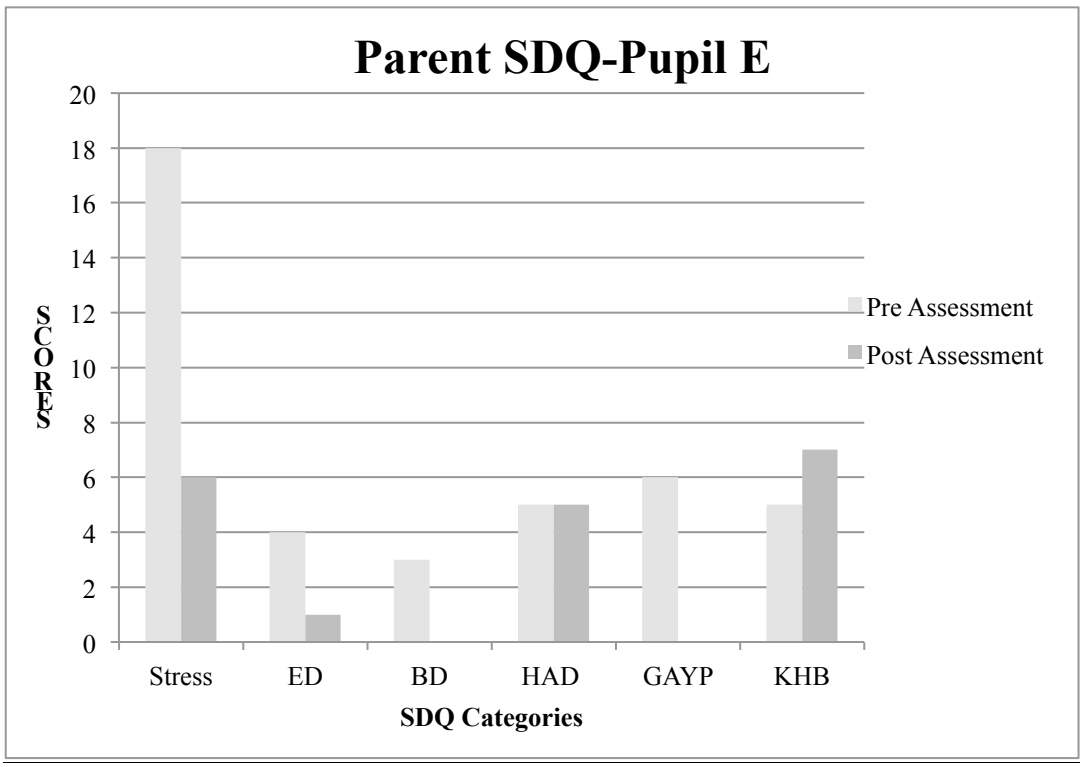

Figure 12: pupil E's parent reported a decrease in Stress, ED, BD and GAYP. The scores for HAD remained the same and KHB scores had increased at the post intervention assessment.

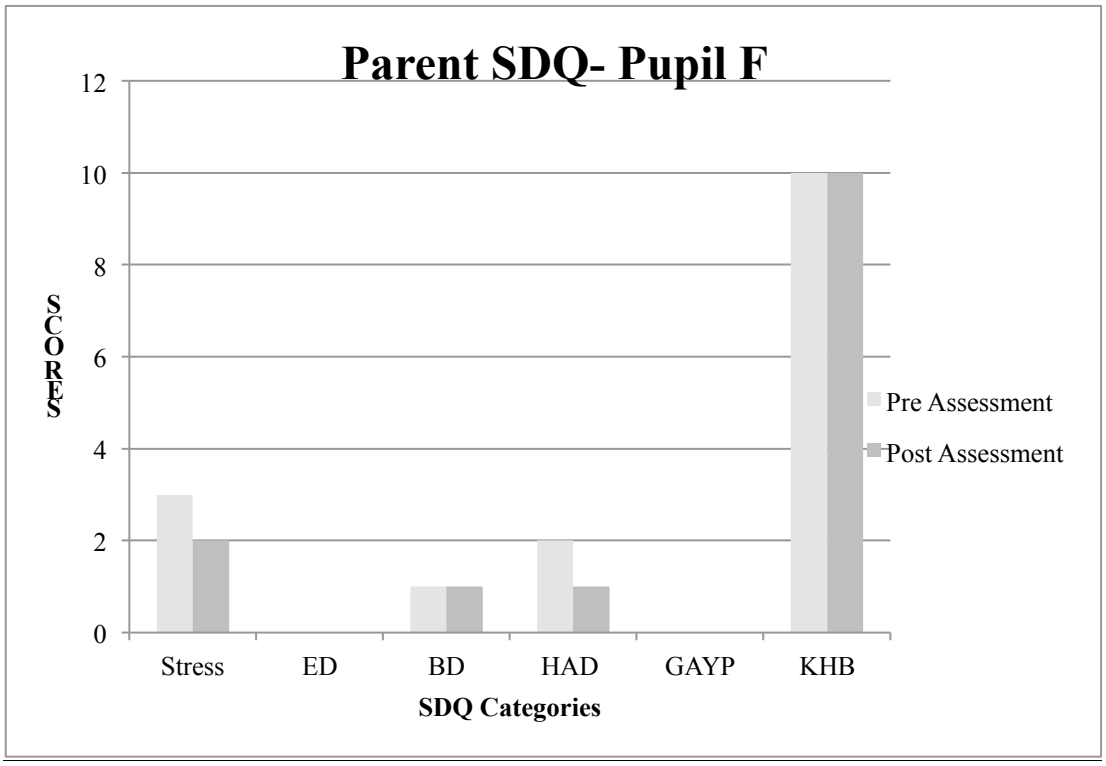

Figure 13: pupil F's mother reported a decrease in Stress and HAD while all other SDQ scores remained the same at the post intervention assessment.

Teacher SDQ responses, pre and post intervention

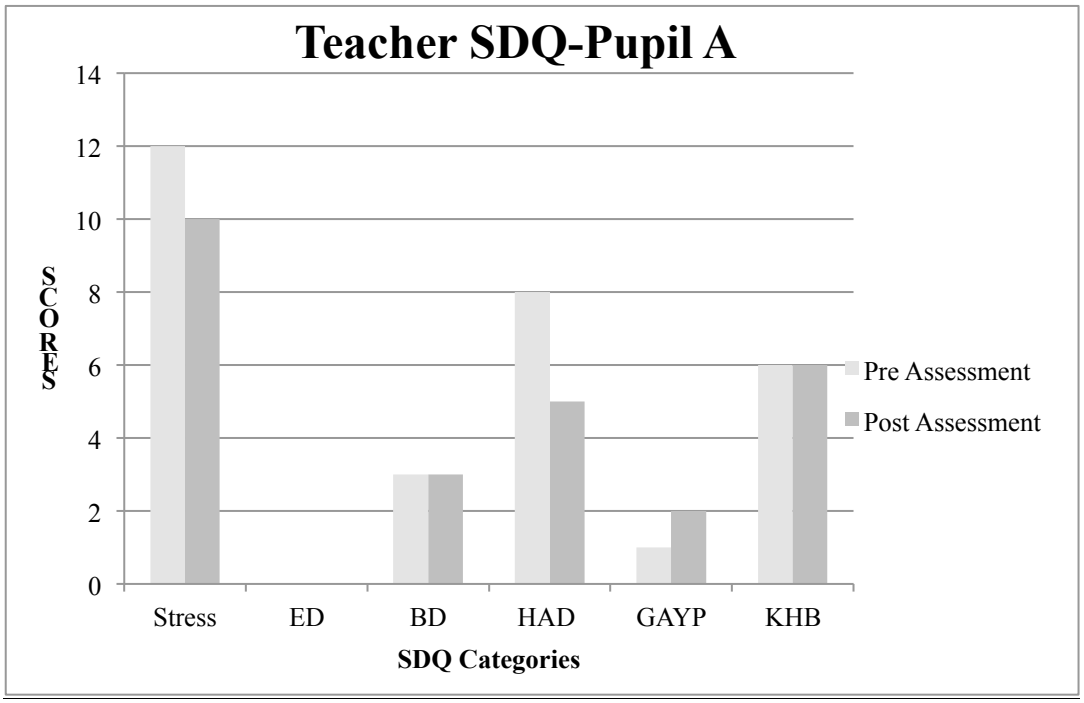

Figure 14: the teacher reports for pupil A highlighted a decrease in Stress and HAD. Scores for BD and KHB remained the same and scores for GAYP increased.

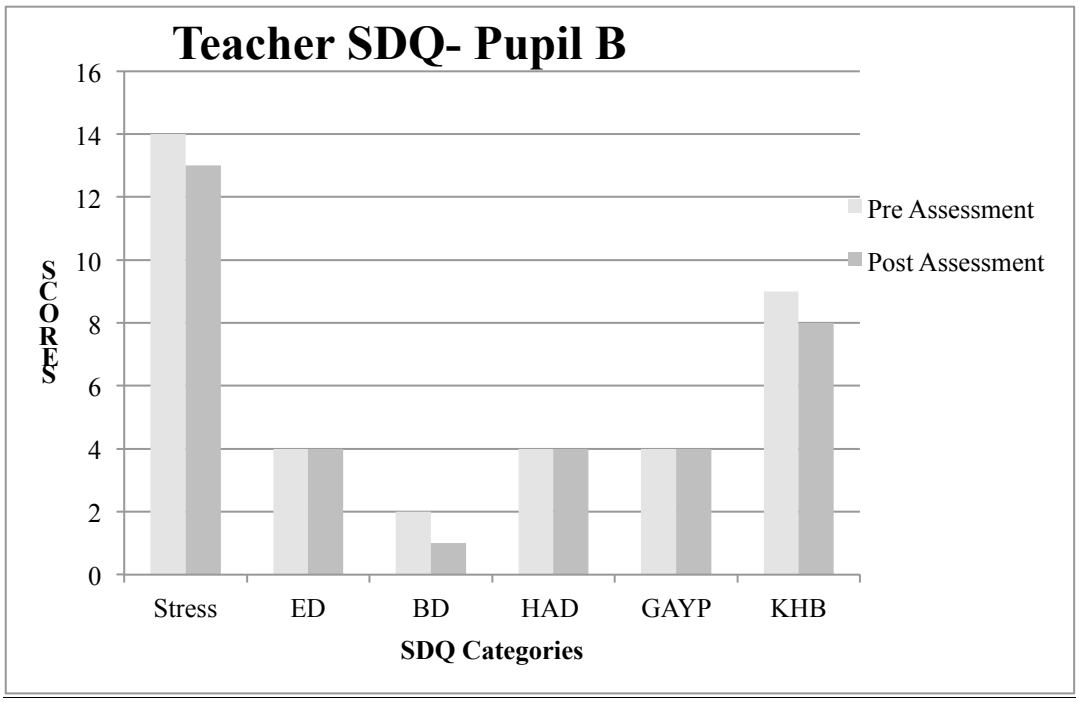

Figure 15: the teacher reports for pupil B highlighted a slight decrease in stress and a decrease in BD. Scores for ED, HAD and GAYP stayed the same. The teacher reports also noted a decrease in Kind and Helpful Behaviour.

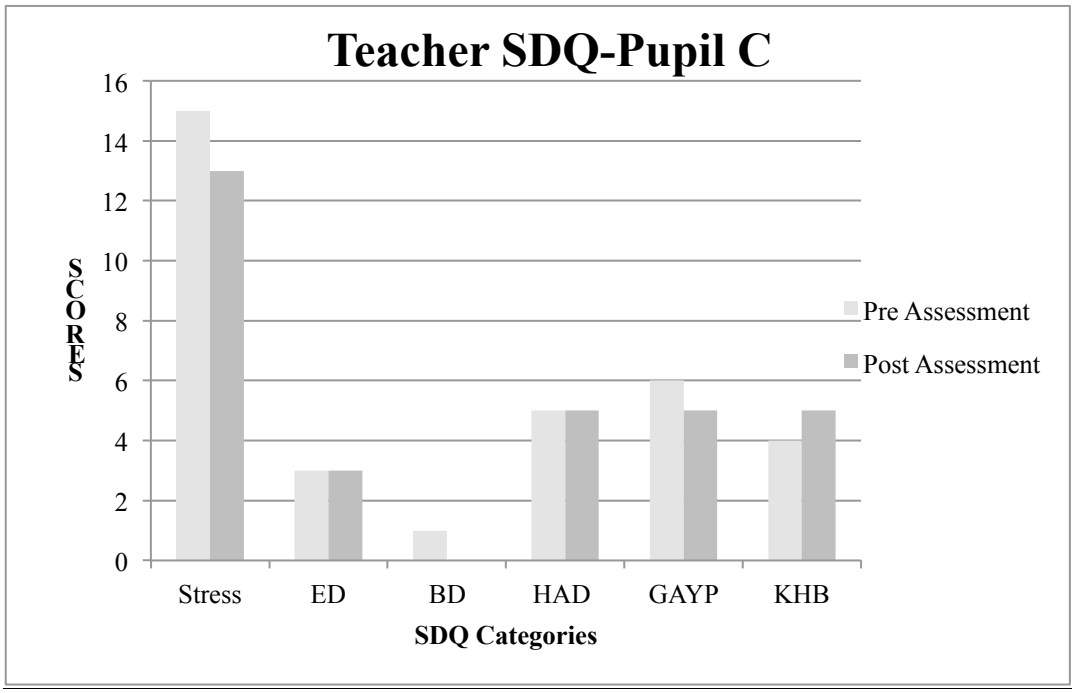

Figure 16: The teacher reports for pupil C showed a decrease in Stress and GAYP. Scores for ED, BD and HAD remained the same. Scores for KHB also increased.

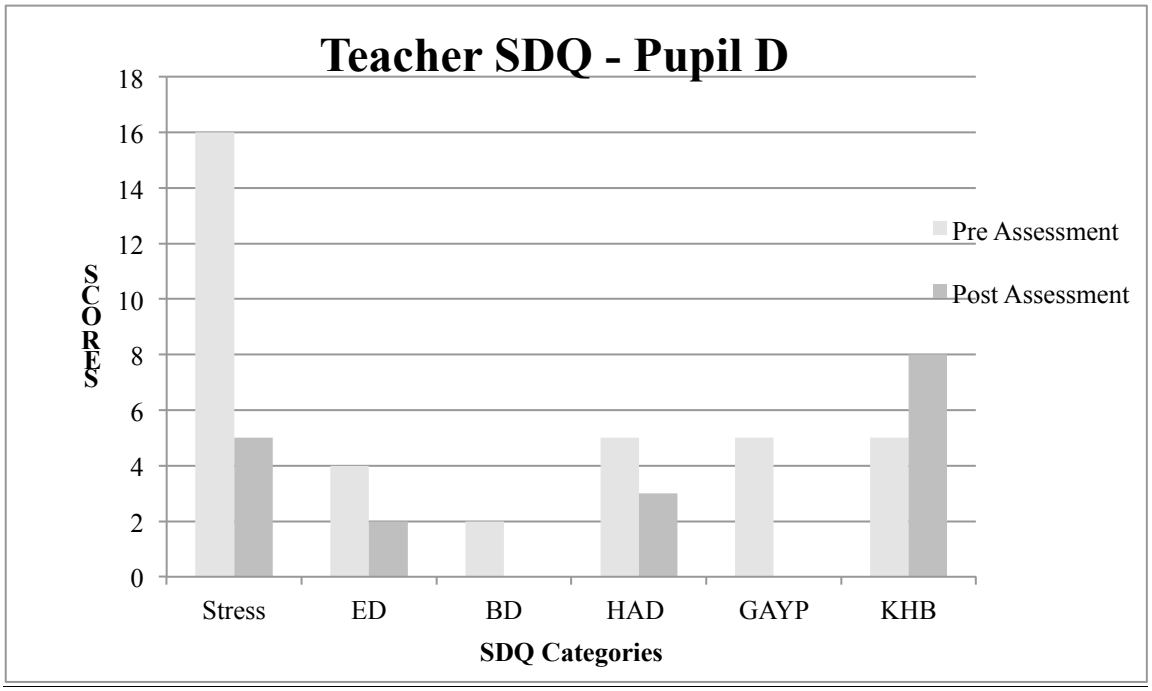

Figure 17: the teacher report for pupil D highlighted a lower score for Stress, ED, HAD, BD and GAYP. The teacher reported also showed a higher score for KHB at the post intervention stage.

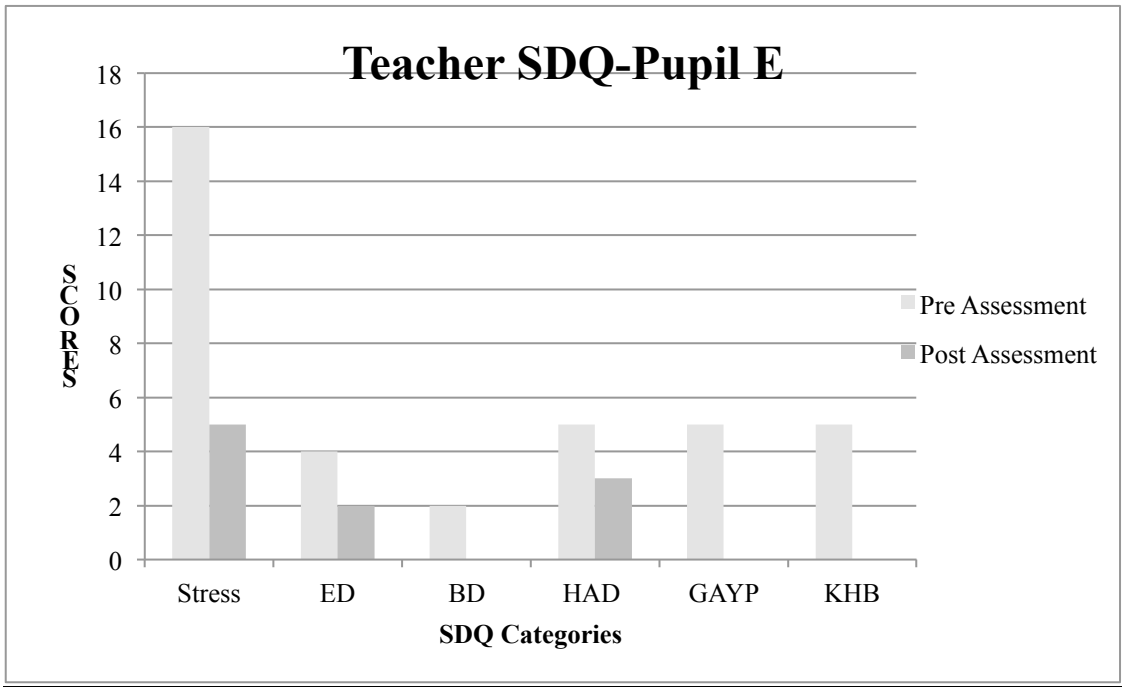

Figure 18: for pupil E, the teacher SDQs reported a lower score for Stress, ED, BD, HAD, GAYP and KHB.

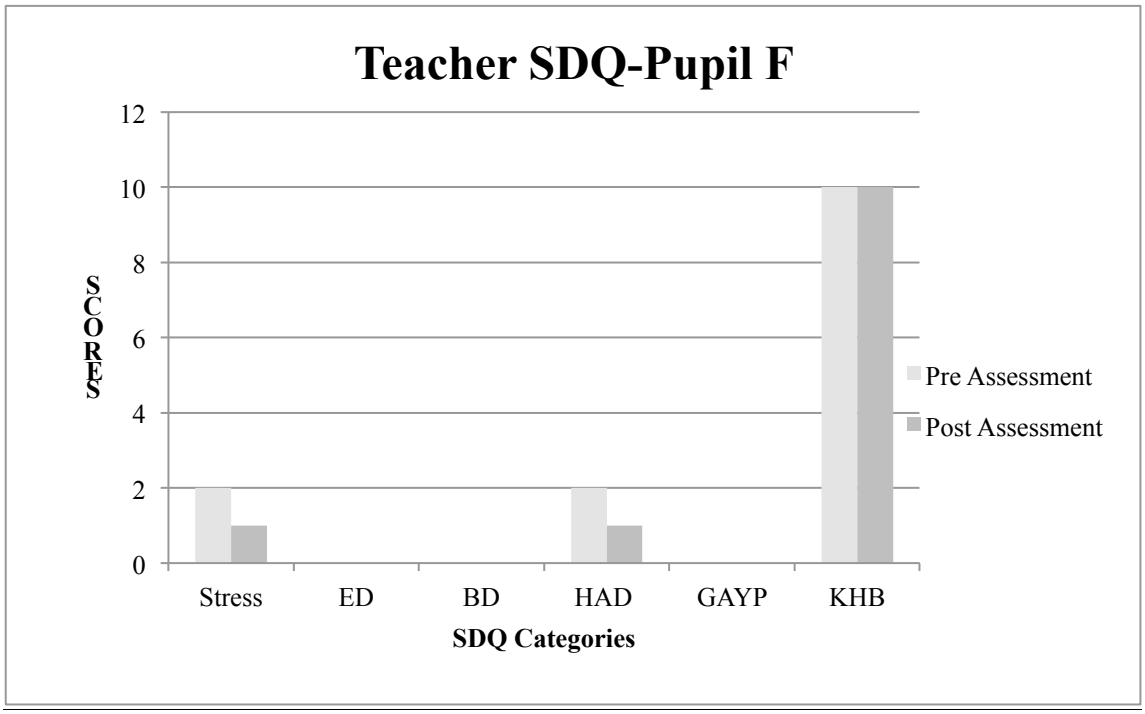

Figure 19: for pupil F, teacher reports on the SDQs pre and post intervention highlighted a lower score for Stress and HAD. Scores for ED, BD, GAYP and KHB remained the same.

Summary of Semi-structured Interviews.

All six parents and pupils took part in pre and post intervention semi-structured interviews. Both the parents and pupils were asked a series of interview questions.

Before the interventions parents and pupils were asked the following question:

1. What do you hope to gain from these group sessions?

Although this was a broad question it was important to discuss parental/pupils hopes to understand their expectations for the group intervention.

Table 1 below is a summary of the comments made by each family at the initial interview stage.

Table 1:

Parent and Pupil	**Comments**
Pupil A and Parent	**Pupil A**: "I'm not sure what the groups are about, but I would like to meet other children who have the same problems in school and at home that I have. I would also like to stop losing my temper". **Parent**: "I would hope that Pupil A finds some strategies to help him express his emotions", I would like for him to be able to tell me how he is feeling". "I am looking forward to the parents group because I would like to meet other parents of children who have Asperger's Syndrome". "I would also like help from professionals so I can learn different strategies for dealing with Pupil A's behaviour at home.
Pupil B and Parent	**Pupil B:** "It will be really good to meet other children and make

	some friends." **Parent**: "I would really like some advice with helping Pupil B with his anxiety. He gets anxious and then lashes out or he withdraws and I am worried that he is going to get excluded from school. He is so quiet so I would really like for him to open up with other pupils in the group and make friends".
Pupil C and Parent	**Pupil C:** "To make friends". **Parent:** "I am worried about how she will manage in a room with five boys. She does find it hard to express her feelings so this group may not be beneficial for her if she does not participate fully. I would hope that by the end of the group she is able to understand emotions and express these in her own way".
Pupil D and Parent	**Pupil D:** "I would like to meet new people and make some friends. I am also really hyper and I would like to calm down. I know this stresses my mum out a lot". **Parent:** "I know a little about Asperger's Syndrome, what I have picked up from books and the internet. I would like to learn more about how children who have Asperger's Syndrome view the world and as a parent I would like to know what I could do to help him make sense of his world, so that he does not feel anxious and stressed."
Pupil E and Parent	**Pupil E**: "Umm I don't really know", **Parent:** "He is very quiet and shy and I am worried that he does not know how to stand up for himself against school bullies. Other children can sometimes take advantage of him. He lacks a lot of confidence so I hope this group will help him build his

	confidence." "I would also like to know whether I am doing the right things at home and I would like to learn more about Asperger's Syndrome".
Pupil F and Parent	**Pupil F:** "I would like to know how to not get annoyed by my sisters, they are always doing things which make me angry and then we get into fights. I can't help it they are older than me and they know how to pick on me". **Parent:** "I hope that Pupil F learns to listen and follow my instructions. It's very frustrating to ask him to do things as he never listens to anything I say. I would also like him to learn how to calm down. He gets angry very quickly".

A number of the pupils found it difficult to verbalise their views and where unable to express what they hoped to gain from the groups. However, most of the pupils did state that they wanted to make friends with other pupils who had similar difficulties as them. Most parents reported that they would like to gain more knowledge about Asperger's Syndrome.

Table 2: Comments made by pupil and parents at the post intervention interview

The question parents and pupils were asked included:

1. Do you feel that your expectations were met in the six week interventions?

Pupil and Parent	Comments
Pupil A and parent	**Pupil A: "**I really enjoyed the group and made some friends with Pupil D and Pupil F. I think I have calmed down a lot since I have been going to the groups. I have used that tool box to help me to calm down when I am angry". **Parent: "**Yes I do agree that Pupil A has used some of the strategies to help him feel calmer. The homework tasks were really useful as we sat together to complete them and then talked about his feelings when we did this." "I did find some aspects of the parents group useful, talking to other parents made me realise that I am not the only person going through these difficulties." "I am still concerned about Pupil A's behaviour and his anxiety behaviours I would still like to be referred for further support".
Pupil B and Parent	**Pupil B**: "I did meet some new friends which was good. I found it really helpful to talk about my feelings with other people in the group". **Parent**: "Although he did make some new friends, I do not feel that he took the group seriously. "He did not always want to do the homework and whenever it was time for the session he did not want to go". "I am still worried that he finds it difficult to manage his behaviour and gets stressed very quickly. The information provided in the sessions have been useful, I hope to continue to use these at home".
Pupil C and Parent	**Pupil C:** "I found the group's fun and I made lot's of friends. **Parent:** "I think she has done really well. I did not think she

	would participate in the group as she is very quiet." "I am really pleased at the friends that she has made and glad that she has opened up." "She does still find it hard to talk about her feelings and is very quiet". "I have found the groups useful, as we are going through the statutory assessment process and it was nice to able to talk to an Educational Psychologist about this."
Pupil D and Parent	**Pupil D:** "I found the groups helpful to talk about my feelings". "I thought it was going to be hard because I was the oldest one there, but I made some good friends. I am sad that the groups has finished". **Parent:** "It has been a tough few months and we have both benefited from attending this group through such a difficult time." "I think he has done really well to use some of the strategies from the emotional tool box. Even the language he uses at home now shows how much he has learned about his own emotions. He is still in his early steps in learning to manage his anxiety, but I do think he has done very well so far". "I have really enjoyed coming here and meeting the parents and talking about the difficulties". I have picked up some good tips and I hope to see some of the people I have met outside the group".
Pupil E and Parent	**Pupil E:** "It was ok, I had fun sometimes". "Yes I made some new friends" **Parent:** "Yes I think the groups have really helped him. I have seen a real difference in his overall confidence". He seems a lot

	happier at school and he has stood up for himself to a bully". "I know he used the role playing that you did in the children's group which he used at school to help him deal with a stressful situation." "I am very proud of him and I hope this continues". "Talking to the other parents has helped my confidence and I feel more reassured at home about how to help him".
Pupil F and Parent	**Pupil F**: "My sister's still bug me, but now I go into my room and try to relax. I took that strategy from the group". **Parent**: "I still find it hard to not become frustrated when he does not listen to my instructions and tries to get his own way". "The groups were as I expected and I do not feel that I got all that I needed from them". "I would like some more support for behaviour management at home".

Overall it appears that many of the pupils and parents found the groups useful to support their understanding of Asperger's Syndrome, to meet other children and parents who shared their concerns and difficulties and to develop some strategies in managing anxiety provoking situations. Two parents requested some follow up targeted support for behaviour management. Other parents seemed positive and could see the changes in their children since their attendance in the group. Some of the children found it difficult to verbalise their understanding of how their expectations were met but were able to explain what had been positive about the group sessions. The children all appeared to have got on well with each other and towards the end of the group the quieter children demonstrated a higher level of engagement.

Discussion

The results of the TRMFs reported an increase in parents and pupils perceptions in regards to achieving their set goal (pre-intervention). All parents and young people who had set a target had felt that they had made some progress towards achieving this target, which linked directly to the group intervention. This suggested that the parents and young people had felt the groups had been useful for them. Some parents and young people had felt that the groups had made much more of an impact on their goals than others. For example, both pupil E and parent E had felt at the post-intervention assessment that they had either achieved their expected outcome or exceeded their expectations. For pupil E in particular, the qualitative information reported that he had used a role-play scenario in a particular social situation. He had previously struggled to stand up to a boy who had bullied him at school. This was a situation that was role-played in the group sessions, where the young people role-played positive responses to this situation. He was able to then use this scenario in a real life situation. This also highlighted the generalisation of a particular skill learnt during the six week intervention. Generalisations to different contexts, a difficulty linked to children with Asperger's Syndrome can sometimes mean interventions such as this and other interventions are limited in their effectiveness (Atwood, 2003).

The TMRFs also showed that many of the expected targets were much higher than the actual targets achieved at the post intervention. This could have been linked to the expectations of the participants being too high and not achievable in the six-week intervention. For example pupil B and his mother both who had expected targets of 7 (pupil) and 5 (parent) had felt that they not moved on from their baseline, suggesting the group intervention did not make any impact on their overall goal achievement. There could have been a number of reasons why the parent and pupil B had felt this way. Firstly the target that pupil B's mother had set "to find a better way to deal with his anxiety", may have been too broad and a more specific and smaller target may have impacted on their overall results. For pupil B who had stated as his target "to make friends with others who have Asperger's type difficulties", he also did not perceive to have made any steps to achieving this target during the six-week groups. It was noted by the professionals who had run the groups that pupil B had found establishing friendships the most challenging aspect of the intervention. Although he had engaged with all activities, completed all homework activities and showed a positive interest in the group, he did find the interaction

with other group members difficult as often is the case for children with Asperger's Syndrome establishing social interaction with peers is a difficulty (Atwood, 2003).

The SDQ results highlighted that for the teacher, pupil and parent reports, the category of stress had shown an overall decrease in reported behaviours. However, for the other five categories there appeared to be great variation in parents, teachers and participants' self-reports. There could be a number of reasons why this was the case. Firstly, due to the nature of the participants difficulties, contextual factors or situations in school could not have been controlled during the intervention therefore, any environmental factors that could have contributed to the participants Hyperactive and Attention, Emotional Distress, or Getting Along with other Young People behaviours may have impacted on the results obtained.

For pupil A, significant differences included that the teacher report had noted that the behavioural difficulties remained the same pre and post intervention, where both the pupil and parent had reported a decrease in Behaviour Difficulties. This suggested a difference in behaviour at home and at school. This could be related to parent and pupils perceptions of the behavioural difficulties at post intervention or possible differences in approach to behaviour management by the parents after post intervention.

For pupil B both parent and participants B had reported a decrease in all categories post intervention. From the teacher's report the emotional difficulties, hyperactive and attention and Getting Along with other Young People categories remained the same. This could suggest that the strategies being taught during the intervention showed that pupil B was not able to generalise these into the school contexts, a difficulty often associated with Asperger's Syndrome (Atwood, 2003)

Although the CBT programme was adapted to meet the needs of children with Asperger's Syndrome as suggested by researchers such as Atwood, (2003) and Drinkwater and Stewart, (2002) through, for example, having shorter sessions, using visual methods of assessment and teaching and by using themed materials to suit the children's interests, it appears the process of generalising new cognitive skills remained a difficulty for pupil B.

For pupil D there was an increase in Emotional Distress and Behavioural Difficulties reported by the pupil's self-report and parent's self-report. The teacher's self-report noted a decrease in

both these categories. As pupil D's grandmother passed away during the intervention this would have impacted on the reports by both the parents and the participant.

Pupil E had shown a decrease in reported behaviours across all categories for the teacher, parent and pupil reports at the post intervention stage. Behavioural observations and information obtained at the interview stage highlighted a level of motivation from pupil E to engage in the process. He had a level of motivation during the sessions and completed all homework tasks. This could have impacted on the results obtained.

Overall it appears that the results of this study report some changes to behaviour and thinking regarding specific problems for participants and their parents/carers. These results demonstrated some similarities with the findings of Sofronoff et al., (2005) and Sze and Wood (2007). For example, all participants reported an overall decrease in stress related difficulties. Furthermore, parental and pupils' goals on the TRMFs saw a move forward in their thought processes regarding the specific difficulties they had identified pre-intervention.

However, there are a number of limitations of this study that need further discussion. Firstly, the sample was small and therefore generalisations to wider Asperger's populations would not be feasible. Also there was only one female participant, so again this would limit the generalisability of these findings to other females with Asperger's Syndrome. Secondly, there were weaknesses in the research design as the use of the self-report survey (SDQ) was the sole method of data collection from the schoolteachers. This limited the findings and further qualitative exploration could have provided more in-depth information regarding the reasons why some changes were seen in the school environment that were not reported by the parents or participants.

Furthermore using SDQs pre and post intervention provided the researchers with some information about specific behaviours. However, on reflection, the SDQ may have been too broad a questionnaire, which meant the information obtained from the SDQs gave little information about the specific strategies that the young people and parents used outside the groups. A more specific questionnaire may have provided information relevant to whether the intervention was effective in managing difficulties relating to social situations and anxiety.

Finally there was no control group used, so again this impacted on the overall validity of the study. Although some results identified reductions in certain types of difficulties on the SDQ,

it cannot be stated for certain that these directly linked to the intervention. External factors, such as environmental, individual characteristics and the level of Asperger's type difficulties could have impacted on the level of engagement in the process by the participants and overall parental co-operation and attitude

Implications for Educational Psychology practice

Rait et al. (2010) discussed the psychological well being of children and young people. The Department for Education, formerly known as the Department for Children and Families (DCSF), stated in the "Promoting Children's Mental Health within Early Years and School Settings" document that, within the UK, the identification and management of the psychological wellbeing of children and young people is no longer solely the remit of the health services and that mental health is everybody's responsibility (DfES, 2001). Furthermore, all adults who work with children and young people are considered to have a responsibility for identifying possible difficulties at an earlier stage and making sure that targeted support is in place.

Rait et al. (2010) discussed the limited resources and the time constraints related to CBT and that it is unlikely that educational psychologists will be in a position to offer regular intensive direct CBT to individual children and young people. Although educational psychologists such as McKay (2002) have argued that this may well form an increasing element within an applied educational psychologist's portfolio of skills. However, some health professionals could argue that there are other services that are better equipped and are more likely viewed as cost effective to use CBT rather than educational psychologists.

However, the working knowledge of the school system, its constraints and impact on the way in which children learn and behave is a unique skill set that educational psychologists have. They can be viewed as best able to provide support for school staff, who could be more directly involved in the delivery of CBT programmes. Also at a whole school level they can promote the development and implementation of more universal and non-selective cognitive behaviour interventions imbedded in programmes such as SEAL in preventative practices that are accessible to schools and non-stigmatising to children and more acceptable to parents (Rait et al., 2010) and make schools more therapeutic environments.

Conclusion

There appears to be a large body of research that identifies the effectiveness of CBT as a treatment for psychological disorders (Rait et al., 2010). However, much of this research is collated from studies with adults. Although the research into CBT with children and young people has highlighted some effectiveness (Atwood, 2003), there have been some weaknesses in the research identified, such as a lack of research into CBT versus other intervention methods, a lack of robust evidence regarding long term impact of the CBT interventions and the limited evaluation data from other sources such as the school environment. Furthermore, much of the research highlighting evidence for the use of CBT with children and young people who have an Autism Spectrum Disorder appears to rely heavily on parental reports of behaviour change or symptom reduction which are not a true reflection of the effectiveness of the CBT approach.

The intervention discussed as part of this paper aimed to gather both qualitative and quantitative data pre- and post-intervention. The results of this project highlighted some changes, particularly in parent and pupil perceptions of change. Using the TRMFs, both parents and pupils identified a change in perception regarding their difficulties. Other methods of data collection did not demonstrate an overall reduction in symptoms. In order to assess any long term change a follow-up evaluation would be required but was not possible in this study.

Overall it can stated that there is some evidence to suggest the use of CBT programmes for children and young people diagnosed with an Autism Spectrum Disorder, However, at this stage the evidence base is still in its early stages. More robust research where children's progress is monitored over time would be beneficial.

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APPENDICES

1- Group session outlines

2- Target Monitoring and Review Form

3- SDQ questionnaire

CAMHS/EP – Asperger's Social Skills Group

Week 1

1) Welcome / introductions (15 mins)

- Welcome

- Children state names/schools/favourite film

- GAME: Remember names round robin

- EXPLAIN purpose of group:

    - how to get along with people
    - how to avoid getting into trouble/getting angry
    - how to understand our emotions

- EXPLAIN: Everybody finds these things difficult sometimes, and here we are going to learn some tips about these things, and play some games to practice what we have learnt. Should be useful but also really fun. Good way to make new friends.
- FILL OUT part A / B in file

2) **Ground rules/shop (10 mins)**
   - Form ground rules (make sure jointly agreed and positive) (E.g: Listen to each other; Be nice to each other; Take it in turns to talk)
   - Write out ground rules and put on wall
   - Explain shop: In the corner of this room, we have a sort of shop where each week, you may be able to buy some prizes. You can earn these prizes by collecting these stickers. We will be giving these out from time to time to the people who are keeping the ground rules (award to someone listening well). Keep these on the piece of paper at the front of the folder (NB Keep total to yourself – private until end). At the end of the group you will take it in turns to go and spend them in the shop, or you can save them 'til next week.

3) Explore being happy (25 mins)

- Brainstorm – things that make them happy?
- Rope game (Part 1) Stand on length of rope/string for different scenarios with one end representing not very happy, the other end representing very happy.
    - Possible scenarios's
        - You are allowed the day off school
        - You get an A for a school assignment
        - You are invited to a birthday party
        - You find and can keep £10
        - Your mother says that she loves you

- SEAL pictures – are they happy / how do we know?
- Discuss physiological / emotional responses to being happy and put on paper. I will draw out and annotate large picture
- FILL OUT part C / D in file

Break (15mins)

4) Being Happy Cont..

- Rope Game (part 2)

In 2 groups place the following words that describe the different levels of happiness at the position on the rope that measures the strength of the feeling.

Happy	Thrilled	Delighted
Ecstatic	Satisfied	Hopeful
Joyful	Pleased	Merry
Cheerful	Enthusiastic	

- Compare ropes and discuss.
- Put words on previously drawn picture

5) Explore relaxation (20 mins)

- Discuss what they do to relax

- Physiological/psychological reactions to being relaxed

- FILL OUT file

- Techniques for relaxation

- Look at 'Ways To Calm Down' handout.

- Practice relaxation exercise/meditation technique – go to special place.

- Discuss their special places

6) Explain Home-task & Shop (5 mins)

- Home project – complete happiness diary

Session 2

Welcome and review of last session 5mins

- Welcome to all GAME: one thing you can remember about another person from last week

- Let's see if we can remember what rules we agreed at the last session.

- Does anyone want to share their homework today? Things that make you happy.

Exploring Anxiety

We all have times when we get anxious, but we need to find a way to help us deal with this so that it doesn't hurt us or others around us.

Exploring anxiety 10mins discussion

What kinds of things make us feel anxious?

Use thermometer to show that some things makes us more anxious then others.

Use rope game again to show on scale some scenarios make us anxious then others: (Print off cards).

What happens to our bodies when we get anxious?

- talk about some of the physiological names (draw picture of person on flip chart)

What are we thinking when we are anxious (do thought bubbles on the flip-chart)

- heart rate
- breathing
- muscles
- posture
- face
- speech
- thinking

Game: list of word to describe anxiety this will include non-anxiety related words too,

Anxiety /other…children given cards with words to describe anxiety and other non anxiety related emotions/words

Choose which ones go to the an section on flipchart.

15 minute break

Think of a hero who has become anxious

- why were they anxious
- how did they feel
- how did they cope with the anxious feeling
- what did they do or think that stopped them from being anxious

Things that make you angry 15 mins

- What happens when you get anxious?
- What does this look like (posture, face, speech, breathing, so on)
- What are you thinking (thought bubble)
- What are you feeling?
- Use traffic light worksheet. (on a scale of 1-5)
- What could you do differently

Introduce emotional tool box 5mins

As much as we have a tool box full of different tools to repair a machine, we could imagine another type of tool box to repair some or our feelings. There could be different types of tools in your emotional tool box. One type of tool in a mechanics tool box is a hammer. A hammer could represent physical activities that use up lots of energy that can "repair" feeling anxious. Another tool in a tool box is a brush to brush away the dust. This could represent things you can do to help you relax.

Homework task

Things to put in your emotional tool box that will help you stop feeling anxious

E.g. tools such as relaxation techniques we used last week.

Session Three

1) **Review** ***(5 mins)***
   Review rules: Who can remember?

   Name game: Throw ball to other in group and say name

   Or tell us something interesting about week/weekend

2) **Review of last session** ***(20 mins)***
   a) Words/faces for emotions
      i. Brainstorm words for worry/anger/sadness/happy
      ii. Quick role play – children act out emotion on a card while others guess (i.e. review of body/facial responses to particular emotions)
   b) Discuss what each participant discovered about physical and relaxation tools used by themselves/others. Can they give an example of when they have used a tool in the last week.

3) **Investigate other tools from emotional tool box – write on flip chart paper (Put all flip sheet paper on wall for all to see)** ***(25mins)***
   a) Social tools (e.g. talking to a friend/teacher)
   b) Thinking tools (e.g. cognitive restructuring - Saying word to themselves, think happy thoughts, count to 10)

c) Other tools (special interest that can be used as a relaxant; consider humour)
d) This can include relieving feelings through physical and abuse; running away.

4) ROLE PLAY ***(20 mins)***

a) Split into two groups and pick a situation that one of the participants has had in which previously they have made use of an inappropriate tool. As a group choose what might be a appropriate tool to use instead.
b) Show short role play to other group

5) Practice going to special place (5 mins)

6) **Home Task:** During week think of different physical/relaxation/thinking and social tools that may be useful for them. If possible try one out to report back to the group next week.

<u>Session 4</u>

(5 mins)

- Activity to start session throw ball to each other and discuss "one thing that has gone well this week, at home or at school."
- Review rules of the session "can anyone remember a rule."

(5 mins)

- Review of task -emotional tool box, has anyone used an emotional tool from their tool box. What happened, what tool you used?
- Place the tool on the flip-chart

(10 mins)

Activity to review emotional tool box from l last week.

- Activity: Emotional tool box rope game.
- A list of scenarios that can cause us to become angry
- Where would this situation go on the rope "a little angry" or "very very angry"
- Different situations may require different emotional tools.
- Sum situations may require more then one tool.

(30 mins)

Rope exercise for anxiety

- Use a length of rope as a 'thermometer' to measure the degree of feeling. With each of the situations, discuss why each of the participants have chosen a particular 'degree' of expression. Consider the person who has shown the least anxiety and discuss how they would cope, making note of their strategies for use by the others.
- Being sent to the Head teacher's office.
- Your usual teacher is away today and the replacement teacher is someone you have not seen before.
- Your morning session has changed from literacy to another lesson which your are not familiar with.
- Two boys that tease you are coming towards you in the playground.
- Then generate a list of all the situations that the participants find cause them anxiety.
- Select a couple of examples.
- Brain storm activities/strategies that could help the person in that situation.
- Role-play one example each.

Practice going to special place (5 mins)

Homework task (5mins)
Home work task is to think about 1 thing you can do that will help you feel less anxious in a situation that causes anxiety for you.

<u>Session 5 – Social Skills</u>

7) **Starter** ***(8-10 mins)***
    a) Review rules: Who can remember?
    b) Throw ball to someone and say something positive about them (e.g. I like your contributions in the group / You are very sharing / you are a good listener, etc

8) **Review** ***(10-15 mins)***
    a) Who has used a tool from the tool box over the last week – can they explain?
    b) Show & tell – has anyone brought in any new 'tools' that we can put on the board

9) **Discuss and write social stories – 25 mins**
    a) Explain we are going to jointly write some social stories for when we get angry or anxious.
    A social story is a description of a social situation to enhance child understanding so that this may lead to more adaptive behaviour.

E.g:

Situation: Many children like to play football at lunchtimes. Often a lot of people play with no teacher there to referee the game. Often rules change or children break the rules of the game.

My view: Sometimes the rules are broken by players on my team, and sometimes by players on the other team. I can get stressed when I see other children breaking the 'rules' of the game. When I get stressed I sometimes confront the child who has broken the rules

What I will do: At these times I will try and stay calm. I will walk away for a short time out and count to 10. I will also put it into perspective by saying 'it is only a game'

Why: This is important as I often get into trouble during lunchtimes. This is the grown up thing to do

b) Split into two groups and discuss one situation that one of them deal with that a social story could be useful for. Jointly write the social situation with the adult as scribe.
c) Groups come together and read out social story

10) Poisonous thoughts and antidotes (15 mins)

a) Discuss what poisonous are; how they can be destructive; remedies/antidotes to them.
b) Read out sentence – stay one sound of the room for poisonous thought and the other for antidote. Read out list and children change sides accordingly.

11) Practice going to special place (5 mins)

12) Home Task: Write social story with parents to read out next week

<u>Session 6</u>

(5 mins)

- Activity to start session throw ball to each other and discuss "one thing that you have found useful/positive about participating in this group."

(10 mins)

- Review of task – Have people written a "social story". Can you think of any situations recently were you could have written a social story to help think about the situation differently.
- Can anyone give examples of poisonous thought (they may have experienced this week) and antidotes to these thoughts?

(25mins)

Task to review emotional tool box and social stories.

- Group of 3
- Discuss a real life situation and describe how you feel using thermometer
- Discuss which tools you can use from your tool box **Physical tools, Relaxation tools, Social tools and thinking tools.**
- Now write a social story to help you think of what you could do and why.

Creating antidotes to poisonous thoughts

(10 mins)

- Draw a picture of yourself and draw thought bubbles of all the antidotes you can use to stop your poisonous thoughts.

Review all strategies discussed in the sessions

(10 mins)

- **Emotional tool box**
- **Social stories**
- **Antidotes.**

Practice going to special place (5 mins)

Certificates of participation presentation at the end.

THE PSYCHOLOGY SERVICE

TARGET MONITORING AND REVIEW FORM

Version 6 (September 2009)

PHASE 1 – PLANNING AND TARGET SETTING MEETING (PLAN)

	Date of Planning and Target Setting Meeting:				
	Commissioner / Problem Owner:				
	Form Completed By:	ZA/Mrs ******* and *******			
	Proposed Date of Monitoring and Review Meeting:	19th April 2010			
	Descriptor of Type of Work[1] Linked to one or more of the ECM indicators, ***and*** indication of primary need Behaviour, Social-Emotional, Language and Cognition and Learning.	***Casework Individual***	***Casework Group***	***Project Work*** ***(Please specify)***	***Other (Please specify)***
		B SE L C&I ***1 2 3 4 5***	***B SE L C&I*** ***1 2 3 4 5***	***B SE L C&I*** ***1 2 3 4 5***	***B SE L C&I*** ***1 2 3 4 5***

[1] To be healthy(1), Stay Safe(2), Enjoy and Achieve(3), Make a Positive Contribution(4) and Achieve Economic Well-being(5).

Some Prompts:-

- *Why is this work needed, who is requesting this piece of work, and what are the specific questions?*
- *What has already been tried, by whom and what were the outcomes?*
- *Are there any other on-going related projects or initiatives (who, what, where and why).*

Joint CAHMS and EPS social skills intervention. Due to a high waiting list for CAHMS a initiative was introduced through consultation with EPs and CAHMS. Children with an ASD diagnosis with anxiety and anger related difficulties were referred for new initiative.

PHASE 2 - AGREED INTERVENTION PLAN (DO)	**Some Prompts:-** ▪ Content – (the *what*). ▪ Process – (the *how*):- ▪ Resources Required:- ○ *Time needed (to include time to project manage, supervise staff, administration, if appropriate).* ○ *Personnel (Who) (to include other practitioners, if appropriate).* ○ *Venue (Where).* ○ *Other.* ○ *Time costing (i.e. in number of sessions).*

Based on the Atwood exploring feelings training package.

Six 1 hour sessions

One CAHMS professional and one EP

To be held at CAHMS

Time allocated for planning each session, organising handouts, resources and activities.

PHASE 3 – TARGET REVIEW MEETING (This page can be separated for analysis purposes) (REVIEW)					
	Date of Review Meeting:	19th April 2010			
	Commissioner / Problem Owner:	****** and Mrs ******			
	Form Completed By:	ZA			
	Descriptor of Type of Work[2] Linked to one or more of the ECM indicators, ***and*** indication of primary need Behaviour, Social-Emotional, Language and Cognition and Learning.	***Casework Individual***	***Casework Group***	***Project Work*** ***(Please specify)***	***Other (Please specify)***
		B SE L C&I ***1 2 3 4 5***	***B SE L C&I*** ***1 2 3 4 5***	***B SE L C&I*** ***1 2 3 4 5***	***B SE L C&I*** ***1 2 3 4 5***

TARGET 1:

Lower Limit	*Descriptor of **Baseline (B)** and **Expected (E)** Level:*	**Upper Limit**
(a rating of 1 means ?)	**Ratings:** To find a better way of dealing with his anger. 1 2 3 **4B** 5 **6A** **7E** 8 9 10 *Descriptor of level achieved at review meeting **(Actual Level (A)):***	(a rating of 10 means ?)

[2] To be Healthy(1), Stay Safe(2), Enjoy and Achieve(3), Make a Positive Contribution(4) and Achieve Economic Well-being(5).

TARGET 2:

Lower Limit (a rating of 1 means ?)	*Descriptor of **Baseline (B)** and **Expected (E)** Level:* **Ratings:** To make friends who have Asperger's related difficulties 1 2 **3A** 4 **5E** **6A** 7 8 9 10 *Descriptor of level achieved at review meeting **(Actual Level (A)):***	**Upper Limit** (a rating of 10 means ?)

TARGET 3:

Lower Limit (a rating of 1 means ?)	*Descriptor of **Baseline (B)** and **Expected (E)** Level:* **Ratings:** 1 2 3 4 5 6 7 8 9 10 *Descriptor of level achieved at review meeting **(Actual Level (A)):***	**Upper Limit** (a rating of 10 means ?)

PHASE 4 – AGREED NEXT STEPS:	**Please specify agreed next steps:**

APPENDIX

GUIDANCE NOTES

PHASE 1. – PLANNING AND TARGET SETTING MEETING

- During discussions with the commissioner / problem owner make sure that the targets finally agreed are as SMART[3] as possible and that they are clearly linked to the areas identified as being priorities for intervention (i.e. based on assessments and investigations) and the intervention plan negotiated.
- Make sure that the targets (outcomes / impacts) chosen are significant and substantive.
- Think carefully about how you go about measuring or assessing the baseline levels of these targets and who is best placed to collect this information.
- Use a range of defensible measures and approaches, where possible - some could be used to monitor learning or social / emotional / behaviour and / or act as outcome measures.
- Check that the assessment devices used are valid, reliable and culturally sensitive.
- Ensure that any formal or informal measures you use are relevant and be able to give sound reasons for their use.
- This clarity will greatly assist the task of reviewing and evaluating the impact that your intervention plans have had.

Specific points to follow:

- ***Phase 1*** of ***The Target Monitoring and Review Form*** should be completed at the ***Planning and Target Setting Meeting***. A date for the ***Review Meeting*** should be agreed (***Phase 3***).
- Up to **3 Targets** can be agreed. These should link directly to the ***Agreed Intervention Plans*** (***Phase 2***).
- In **Version 6** we ask that you also define the two extremes of your scale for each target before placing your ***Baseline (B)*** and ***Expected (E)*** ratings. For example, if our goal is by December 2008 for Stewart to be able to read and write 70 of the top 100 basic sight words, then on our scale 1 = 'No sight words' and 10 = "100 sight words". Therefore using this scale Stewart's expected rating would be 7 and his base line (derived from direct assessment) was 1. The intervention chosen included an element of precision teaching and when he was re-assessed in December he was able to read and write 80 of the 100 sight words. This would be rated on this scale as 8 (***Actual Level (A)***.

3 *Specific, measurable, achievable, realistic and time limited.*

- The descriptor of baseline level should be defined first. This should be a behavioural statement derived from IEP targets, curriculum based assessments, National Curriculum targets, P-scales, behavioural sampling, self monitoring and / or other valid sources.
- After a critical review of the information available between the commissioner and EP / Trainee a baseline descriptor is allocated a rating on a scale from 1-10, circled and marked with a **B**. This will normally be at the lower end of the scale (around 2 or 3).
- The level of attainment expected by the review date is defined as a target and written in the space above the shaded box. The commissioner is asked to allocate a rating on the scale to indicate the expected level. This should be circled and marked with an **E.** This will normally be between 6 and 8.
- At the review, a score is allocated for the level achieved, circled and marked with an **A**. A score above the expected level (**E**) indicates more progress than expected, below this, less than expected, or if the same then expected progress.
- A behavioural statement describing the level achieved is recorded under 'descriptor of level achieved'.
- Copies should be made for the commissioner, pupil and / or school files as appropriate and a copy sent to Joynes House Support Staff.

PHASE 2 - AGREED INTERVENTION PLAN

Points to Consider

- During discussions with the commissioner about intervention plans try and maximum the involvement and commitment of child (children) concerned.
- Try and plan for the 'realistic' involvement of staff, and parents / carers in terms of time and effort required to implement the plan.

Ask yourself:

- *Is the intervention ethically and culturally sensitive?*
- *Do the persons involved have the skills to implement the intervention(s)?*
- *Is the intervention based upon sound principles and / or research?*
- *Are all parties agreeable to the intervention?*
- *Is the intervention practical?*

State clear aims and teaching tasks: these may be in the form of a checklist:

- *The instructional objective/s.*
- *The specific learning and / or behavioural outcomes: what is it you want to achieve?*
- *Under what conditions and when will it happen?*
- *Criteria for success, how will you know when you have achieved what you set out to?*

Specific intervention steps:

- *Include how you intend to guide the learning and reinforce that learning.*
- *Include adaptations and how you will manage resources for most effective action.*
- *Deal with possible obstacles (e.g., child absence, distractions and emergencies).*

Describe the monitoring system. Describe how you will facilitate maintenance and generalisation of procedures.

- *Provide detail on the planned actions.*
- *Summarise progress and issues (e.g., what was the impact on each behaviour / dimension of interest?);*
- *What was the impact on the specific areas of concern and wider systemic issues?*

PHASE 3 – TARGET REVIEW MEETING

Points to Consider

- During discussions at the ***Review and Monitoring Meeting*** consider outputs, outcomes and impact. How will these be reviewed? What information needs to be collected (further assessments, observations, feedback) and by whom?

Critically analyse issues specific to the intervention and wider systemic issues relating to assessment, evaluation and teaching:

- *Is the data sufficient to allow for a determination of success?*
- *Does the data show a consistent pattern or are there inconsistencies which could point to a more successful intervention?*
- *What problems were encountered in implementing the intervention?*
- *What are the factors associated with positive/negative outcomes?*
- *How does the outcome relate to relevant literature and your experience?*
- *Did the intervention increase or decrease the others' professional dependence on you?*
- *Did it enable others to solve future problems more effectively?*

PHASE 4 – AGREED NEXT STEPS

Points to Consider

- During discussions at the ***Review and Monitoring Meeting*** in consultation with the commission a clear decision will be agreed as to what will happen next. Obviously this decision will be dependant on the outcomes of the intervention (i.e. a new brief / commission will be negotiated, the direct involvement of the EP will cease, a monitoring role will be adopted, and so on).

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of how things have been for you over the last six months.

Your Name ..... Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others (food, games, pens etc.)	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I am usually on my own. I generally play alone or keep to myself	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have one good friend or more	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, down-hearted or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often volunteer to help others (parents, teachers, children)	☐	☐	☐
I think before I do things	☐	☐	☐
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get on better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I finish the work I'm doing. My attention is good	☐	☐	☐

Your signature ..... Today's date .....

Thank you very much for your help

CONCLUDING CHAPTER

This chapter is a concluding summary of the work undertaken during my two-year placement within the Kent Educational Psychology service as part of the assessed requirements of the Applied Child and Educational Psychology Doctorate at the University of Birmingham.

My role as a Trainee Educational Psychologist (TEP) included work within two different locality teams within a large local authority. This experience provided me with an understanding of the complexity and variety of the role of the Educational Psychologist. My work ranged from individual casework to multi-agency work in collaboration with Child and Adolescent Mental Health Services (CAMHS).

My role within the Dartford team in Year 2 provided me the experiences of working collaboratively with other professionals to provide services to schools, families and children as part of the Every Child Matters Agenda (DfES, 2003). However the challenges of working in this way included the limited opportunities to build rapport and professional relationships with the Special Educational Needs Coordinators (SENCOs) of the 32 schools within the locality. Throughout the year my involvement with schools was determined through the Partnership Based Review (PBR), which meant that for schools to access educational psychology they had to make a referral to the PBR. I have highlighted in my critical reflection the limitations in this way or working as not all schools were equally represented. Many schools who understood the system were able to access the services more often. According to Imich (1999) the time allocation system is often viewed as equitable by schools.

During Year 3 of my trainee placement, I was able to work within a time allocation model, and reflecting on the equitability of services I felt that I was able to divide my time more equally amongst the schools in my patch. This allowed me to develop professional relationships with the schools I was working with in a view to understand the needs of the school at the organisational level - something I felt unable to do during Year 2, where often my first contact with the school was after they had been allocated the EP time through the referral system.

My work in Year 3 also provided me with an opportunity to develop my skills using a model of consultation based on the principles outlined by Wagner (2000). Working collaboratively with a SENCO to problem solve and reframe a child's difficulty can have a profound effect on the educational outcomes for individuals pupils. My consultation skills are something I hope to build on and continue to apply throughout my professional practice.

The professional practice reports provided me with an opportunity to develop my practices with primary and secondary schools, specialist provisions such as the West Kent Health Needs Services, work with the CAMHS and work within the community context allowing me to apply psychology within a variety of contexts. For example, PPR2 gave me the opportunity to look closely at the evidence base for social stories as an intervention for children and young people with Autism. This allowed me to take an in-depth look at the research and understand the ways in which evidence based practice can develop and check the validity of the interventions we often support schools to implement.

McKay (2002) argues that psychological therapies such as CBT may well form an increasing element within an applied educational psychologist's portfolio of skills. PPR5 provided me with an opportunity to explore the use of CBT and the role of Educational Psychologists. Having an opportunity to analyse the evidence to support the use of CBT with children and young people who are diagnosed with Asperger's Syndrome has helped me to reflect on how important it is to ensure a sound understanding of approaches and interventions psychologists use within their work.

References

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